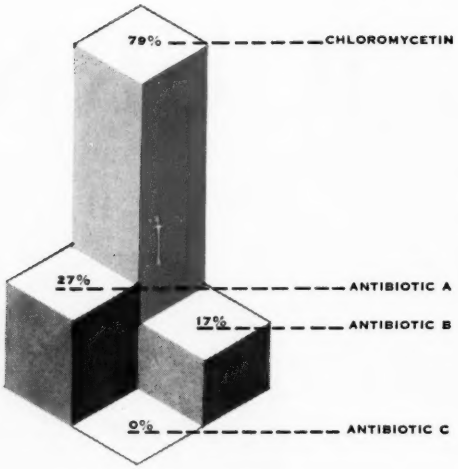
RHODE ISLAND MEDICAL JOURNAL

MARCH, 1956

SENSITIVITY OF COMMON PATHOGENS TO CHLOROMYCETIN AND THREE OTHER MAJOR ANTIBIOTIC



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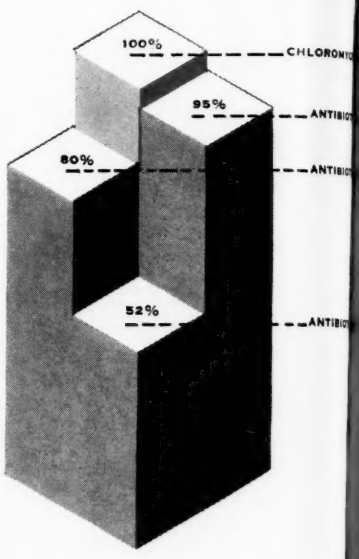

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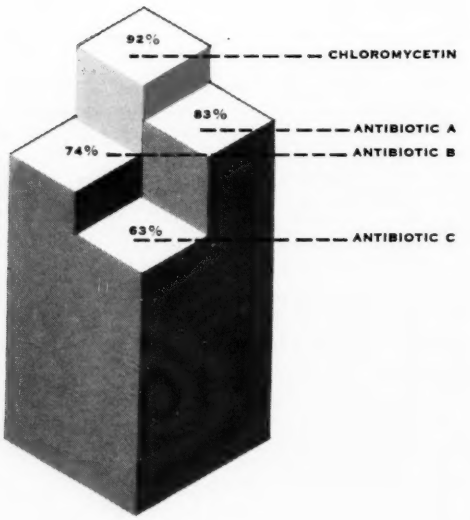

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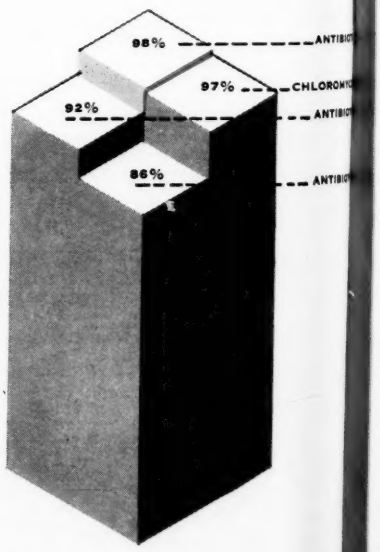

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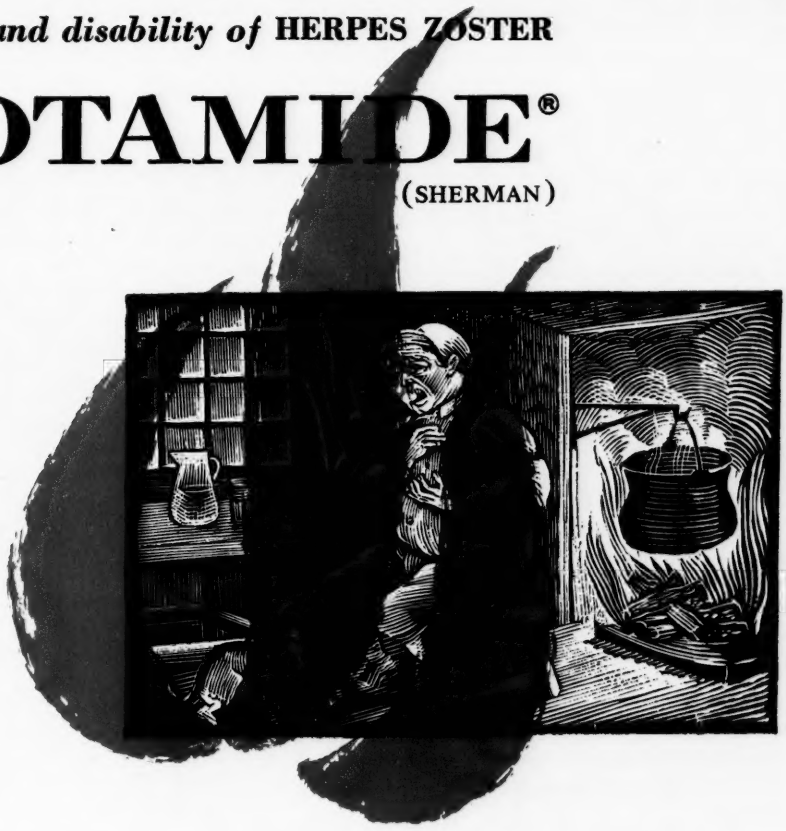

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*Combes, F. C. & Canizares, O.: New York St. J. Med. 52:706, 1952; Marsh, W. C.: U. S. Armed Forces M. J. 1:1045, 1950.

BOOK REVIEWS

CANCER CELLS by E. V. Cowdry. W. B. Saunders Co., Phil., 1955. $16.00

This comprehensive and scholarly work presents the ubiquitous problem of cancer from the histopathologic viewpoint primarily.

The first few chapters are taken up with the usual problems of definition, growth features, differentiation and anaplasia. Then the orientation is more cytological and the various problems and facts of cytomorphology and histochemistry, in relationship to cancer cells, are reviewed. One very interesting chapter deals with malignant tumors in various lower vertebrates, invertebrates, and even plants. The author even devotes a brief space to what might be called paleo-oncology, and mentions an osteoma discovered in a dinosaur which perished about 50,000,000 years ago.

The remainder of the book is given over to a discussion of carcinogens, single trauma cancers, mutation, cellular susceptibility, heredity, and latency. Most interesting are the chapters in which unexplained disappearance of well-developed cancer, and delay in metastatic manifestations are discussed.

Of particular value is the appendix giving a list of the various cancer registries, books on cancer, and miscellaneous reports. There is a comprehensive bibliography of over 2,000 references.

In the opinion of the reviewer, this is an excellent reference work and should be in the library of all physicians who deal in any way with this subject.

L. W. FALKINBURG, M.D.

SURGERY IN WORLD WAR II — HAND SURGERY. Edited by Sterling Bunnell, M.D. Medical Department, U. S. Army. Office of the Surgeon General, Washington, D. C. 1955. $3.75

Amidst the wholesale destruction of World War II, very little of a really constructive nature emerged with the exception of faster, more powerful aircraft and more deadly weapons. However, the field of traumatic surgery really blossomed, and with it the emergence of hand surgery as a separate entity. The guiding light of this development was Sterling Bunnell of San Francisco, California, who served as a civilian consultant for hand surgery to the Secretary of War, and who made repeated rounds of the various hand centers in this country and in Europe; advising, consulting, operating, and teaching.

This book is a report containing a brief introduction including the history and development of hand surgery up to the Second World War and the establishment of various hand centers. Following this, Dr. Bunnell summarized the conclusions on the care of injured hands derived from the experiences of World War II. He stresses the importance of primary care with particular emphasis on the importance of proper splinting and the effects of improper splinting.

Harvey Allen and Mather Cleveland report their experiences with hand injuries in the Mediterranean and European theaters of operations. This is followed by reports from the nine hand centers established in the United States. Each of these reports deals briefly with the establishment and operation of a hand center, followed by experiences in the various methods of treatment of hand injuries, specifically skin replacement, bone grafting, mobilization of joints, peripheral nerve surgery, tendon grafts and transfers, amputations, and the reconstruction and transplantation of digits. There is considerable unanimity in the opinions expressed and the conclusions of the nine different authors which is perhaps attributable to the general guidance of Dr. Bunnell.

The book contains a minimum of statistics which is somewhat remarkable in an Armed Services publication. There are innumerable photographs, diagrams, and X-ray reproductions with operative descriptions of various methods of treatment.

It is an excellent reference book for the treatment of any hand injury and the repetition by each of the authors of the various "do's and don't's" emphasizes their importance.

The cooperation at these various hand centers between orthopedic, plastic, neuro, and general surgeon is emphasized repeatedly as well as the problem of rehabilitation following hand injuries. This cooperation could well be carried over into civilian practice particularly in relation to industrial hand injuries.

RICHARD P. SEXTON, M.D.

GLANDULAR PHYSIOLOGY AND THERAPY. Prepared under the Auspices of the Council on Pharmacy and Chemistry of the American Medical Association. 5th ed. J. B. Lippincott Company, Phil., 1954. $10.00

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BOOK REVIEWS

concluded from page 124

A new book on endocrinology prepared under the auspices of the Council on Pharmacy and Chemistry of the American Medical Association. A symposium with a long list of eminent authors who have contributed to make this a treatise of very high standing.

A full chapter is devoted to each of the ductless glands—explaining its normal and abnormal physiology followed with clinical aspects of each. The chapters on thyroid and menstrual physiology were quite complex and hard to read yet fascinating. There is information here on the use of the modern isotopes for diagnosis and treatment. Surprisingly I could find no mention of elevated Uropepsin as a diagnostic aid in Cushing's Disease. The last chapter called *Diagnostic Aids* is short and summarizes most of the text and explains the pitfalls the clinician may avoid. One may refer to this chapter for assistance to a quick diagnosis of endocrine disease.

There are many diagrams—one photograph, in the book. A classic, and I do advise physicians in all fields to read it.

MARK A. YESSIAN, M.D.

POLIO PIONEERS by Dorothy and Philip Sterling. Doubleday & Co., Inc., Garden City, N. Y. $2.75

POLIO PIONEERS is a book written for children between the ages of eight and fourteen to explain in simple language the scientific history of poliomyelitis, what it is, and how mankind is affected by it.

Starting from the early centuries — from the time of Leeuwenhoek who made microscopes, to Louis Pasteur and his work with microbes, to Edward Jenner who invented vaccination, and on to the discovery of the vaccine by Doctor Salk—this book tells all the discoveries, hardships and triumphs of these and other scientists in their search for ways to combat infantile paralysis.

The great efforts in recent years are also recorded, including those of Doctor Enders who found a way to grow the polio virus in bottles, of Doctor Armstrong of the U. S. Public Health Service who taught polio to grow in mice, thus paving the way for the Salk vaccine success, and of Franklin D. Roosevelt whose courage resulted in a nationwide interest in the conquest.

As a result of the mass inoculation of school children with the Salk vaccine in the past two years every child now knows of the disease poliomyelitis. But it remains for POLIO PIONEERS, with its many illustrations and easily readable text, to fill a previously unmet need in the scientific interpretation for boys and girls of how modern research is bringing a halt to polio.

LINDA ANN FARRELL

The RHODE ISLAND MEDICAL JOURNAL

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The RHODE ISLAND MEDICAL JOURNAL

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UNDESCENDED TESTIS*

CHARLES C. HIGGINS, M.D.

The Author. *Charles C. Higgins, M.D., of Cleveland, Ohio. Head of the Department of Urology, Cleveland Clinic; Past President, American Urological Association.*

THE TERM *undescended testis* is usually applied to all cases in which the gonad does not occupy the normal position in the scrotum. Although the term *cryptorchism* is usually used for all forms of imperfectly descended testes, the condition should be differentiated from ectopia as the treatment to be instituted is different.

The testes occupy an extraperitoneal position in the iliac fossae until late embryonic life, and descent into the scrotum is usually present in the last month of fetal life. Kiefer[1] states that incomplete descent occurs in approximately 33 per cent of infant boys born prematurely and in 15 per cent born at full-term. Careful examination reveals cryptorchism to be present during childhood in 3 per cent of boys, while the incidence in adult males is one in two hundred and fifty. Campbell[2] states that the incidence in the young is 1 in 34, in comparison to 1 in 214 in males more than 15 years of age.

There is a relatively high incidence of bilaterality in the young as about 10 per cent are bilateral in late childhood.

Kiefer,[1] from data obtained during his study of the cryptorchid testis, has observed that 45 per cent are outside the external ring, 41 per cent in the inguinal canal and 12 per cent inside the abdomen. Campbell[2] observed that 70 per cent are inguinal in position, 25 per cent are abdominal, while the remaining 5 per cent occupy more unusual positions.

Ectopia implies that the testis in its descent has not followed the normal path. Five types of ectopic testes are described, the perineal, interstitial, femoral, penile and the transverse. In *perineal ectopia* the gonad is attached by the gubernaculum to the spine of the ischium. Campbell states that 105 cases have been reported in the literature. *Interstitial ectopia* is the type of ectopia usually encountered. In this instance the testicle occupies a position anterior to the external oblique muscle. In *femoral ectopia* the testicle will usually be found in Scarpa's triangle. The testicle will be observed at the base of the penis in *penile ectopia,* and finally in *transverse ectopia* both testes pass down the same inguinal canal occupying a position on the same side of the scrotum. When ectopia is present, surgical intervention is required to place the testis in the normal position in the scrotum.

Numerous theories have been propounded to explain the cause of cryptorchism. The two etiologic factors generally accepted are: the mechanical theory and endocrine abnormality. In recent years experimental and clinical observations have demonstrated that an endocrine factor may be the causative agent. In 1952, Deming[3] reported experimental studies consisting of a histological study and comparison of tissue prior to and after the injection of gonadotropic hormone in preadolescent monkeys. He removed a section of the inguinal canal and cord on one side for control purposes. Hormone was then administered and approximately one month later, after the remaining testicle had descended into the scrotum, orchiectomy was performed to permit microscopic study. He observed the following: The testis removed from the scrotum had increased 50 per cent in size, an increase in the interstitial tissue was present and there was observed an increase in the diameter of the tubules. The tubules of the epididymis were larger and the epithelial cell lining of the tubules was taller. The vas had increased in size, was elongated, and there was an increased blood supply of the cord. The cremaster muscle fibers were more than twice the size of those of the controls. The dartos muscle was also increased in size and evidence of increased vascularity was noted. The inguinal canal was definitely widened.

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*From the Department of Urology, The Cleveland Clinic Foundation and The Frank E. Bunts Educational Institute, Cleveland, Ohio; presented at the 144th Annual Meeting of the Rhode Island Medical Society, at Providence, Rhode Island, May 4, 1955.

Deming concluded the same conditions can be produced in the male child by hormone therapy, as was observed in his experimental work in the pre-adolescent monkey, unless obstruction or mechanical abnormalities are present preventing descent of the testis into the scrotum. He stated that the artificially produced tissue changes in the monkey are comparable to those normally observed in the adolescent male child at which time the gonadotropic hormone is present in the greatest amount. This study is an outstanding contribution to the confirmation of the endocrine theory of testicular descent.

If endocrine factors are instrumental in causing imperfect descent, bilateral cryptorchism should be observed. There may also be detected other evidence of an endocrine disturbance such as Frölich's syndrome or hypogenitalism. That endocrine factors may be responsible is confirmed by the observation that some undescended testes descend into the scrotum spontaneously at puberty. This observation has led to conservatism in the treatment of cryptorchism; surgical intervention is deferred, although watchful waiting is not successful in more than 5 to 10 per cent of cases.

There are many anatomic factors described as predisposing to mechanical interference with the normal descent of the testis, namely: short vas deferens, faulty attachment of the gubernaculum, a long mesorchium, short spermatic vessels, tight inguinal rings, small caliber of the inguinal canal, and the presence of adhesions. In my experience adhesions to the adjacent structures, usually to the peritoneum of the processus vaginalis, are usually observed during surgical intervention. Due to a failure of the processus vaginalis to close, a congenital hernia is usually present.

Robinson and Engle[4] have made a detailed microscopic study of more than 150 testicular biopsy specimens taken at the time of orchiopexy, or following operation. In a review of forty-two testicular biopsy specimens that were taken from unilateral undescended testis and the normally descended testis in the same child during the same operation, they observed that up to five years of age there were no gross differences in the size of the tubules. Between the ages of six and ten years it was evident that the seminiferous tubules were increasing in size. Between the ages of eleven and fifteen years, more striking differences were observed. There was a more pronounced difference in the size of the tubules and the normally descended testicle showed signs of spermatogenesis. In contrast to this, the undescended testis showed but little developmental change. In patients more than sixteen years of age, they[4] observed that the cryptorchid testis was growing but the rate of growth was much less than the normal gonad. There was no evidence of spermatogenesis in the undescended testicle, while the normal testicle revealed marked evidence of spermatogenesis. Thus, in the undescended testicles the spermatogenic tubules fail to mature, resulting in failure of spermatogenesis.

A testicular biopsy should be taken at the time of operation as occasionally the cryptorchid testis is hypoplastic and even if placed in the scrotum will fail to develop in a normal manner. A diversity of opinion prevails relative to the question of malignancy in undescended testes. It is generally stated that there is a higher incidence of testicular tumor in undescended testicles than in normal gonads. Dean[5] states the incidence of tumor in undescended testes is twenty-two times greater than in normal testes. Gilbert and Hamilton[6] in a collective review of 7000 cases of tumors of the testes stated that more than 840 (approximately 11 per cent) of the patients had imperfectly descended testes.

Carroll[7] stated from a collective review "Present statistics proving the higher incidence of malignancy in cryptorchidism cannot be accepted. Secondly, the incidence of malignancy in cryptorchidism from the actual cases reported is so minute that the potentiality of its malignancy cannot be used as an indication for either orchiopexy or orchiectomy." I strongly agree with the last statement.

Rusche[8] in a review of the medical records from 8 hospitals in the Los Angeles area collected a series of 131 testicular tumors. Fifteen of the 131 patients had a unilateral undescended testis, and eleven of this group developed a tumor while the other four tumors occurred in the normal mate. Six of the fifteen patients in this series with undescended testis had an orchiopexy performed with later development of the tumor on the surgically corrected organ.

From a statistical review of the literature it may be stated that the danger of developing malignancy in an imperfectly descended testis does not warrant removal of the gonad, and is not the principal reason for advocating orchiopexy.

Treatment

A review of the literature reveals varied opinions relative to the age at which chorionic gonadotropins should be administered and the dosage to be employed.

Since the testicular biopsies reveal that the growth and development of the undescended and the normally descended testicle are quite similar to the age of five years, but after this period the undescended testis fails to keep pace with the development of the normal testis, a clue is presented as to when hormone therapy should be instituted. I believe hormone treatment should be advised before

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MIRACLE DRUGS AND ELECTROSHOCK — WHAT THEY CAN AND CANNOT DO*

MANUEL M. PEARSON, M.D.

The Author. *Manuel M. Pearson, M.D. of Philadelphia, Pennsylvania. Assistant Professor of Psychiatry, University of Pennsylvania School of Medicine.*

IT IS MY PRIVILEGE to be permitted to make some contribution toward this ambitious and important program of the "Common Misconceptions about Mental Health," which your program committee has established for this coming year.

For the purpose of orienting ourselves regarding the chosen topic this evening, I have several slides to show which will point up the extent of the problem of mental health in the United States. These slides will present the current picture and the pertinent statistics regarding psychiatric illness.[1] There are several other interesting facets to be aware of: the largest group of patients admitted to mental hospitals today comes from the older citizens over the age of sixty-five. Whereas in 1900 there were three million people in the United States over the age of sixty-five, today there are fourteen million. The rise in the senile and arteriosclerotic group of psychoses now accounts for 37% of the new admissions to the New York State Mental Hospital System. As an example of what has been achieved in psychiatry in recent years, we may indeed be encouraged by the number of cases of paresis reduced by one half. It is becoming more difficult each year for me to find examples of paresis to demonstrate to my medical school classes.

What is the present outlook of a patient who enters a mental hospital for the first time? He has an 80% chance of being discharged by the end of one year. Even if his illness is schizophrenia, he has a fifty-fifty chance of discharge in a year. Thereafter, his prospects of leaving the hospital diminish rapidly. It is estimated that about 16,000 patients become chronic mental hospital residents each year, spending anywhere up to fifty years as in-patients.

Let us now inspect the "natural history" of the new therapies introduced in psychiatry in the last twenty-five years. These have consisted of new drugs, inhalation of gases, various "shock" treatments, and operative procedures on the brain. Fads exist in medicine as in other areas of our everyday life. It is common to experience an initial phase of optimistic enthusiasm for the new treatment, particularly stimulated by the next phase of supporting evidence for such treatment. The third phase consists of a small number of negative reports that obviously dampens the enthusiasm and brings about the fourth phase, a period of relative quiescence. Finally, after a varying length of time, a very much watered down evaluation of the value and usefulness of the new treatment emerges. As an example, Sakel introduced insulin shock therapy for schizophrenia in 1935 and claimed 85% of very good results. Twenty years later (1955) competent investigators report a 50% to 60% of very good results in early cases, with a gradual falling off of these figures to 20% after a fourteen-year follow-up of the treated cases.[2] It is appropriate to tell the story of the professor of psychiatry who, after reviewing this "natural history" of new therapies, advised his younger associates to "hurry up and use this new treatment while it's still working."

The new "miracle drugs" to be discussed this evening are chlorpromazine and reserpine. The many others recently introduced are of no competition, such as miltown, meratran, frenquel, etc. These "miracle drugs" have been very popular and used extensively, most often for the complaint of anxiety, and estimated by the manufacturers to have been prescribed for over two million people.

The reports in scientific journals range all the way from predicting the doom of psychiatry, pronouncing a new era of therapeutic progress and the closing of mental hospitals, to the sober recognition that the usefulness of these drugs lies in those conditions that are self limited.

What the "Miracle Drugs" Can Do

1. These drugs constitute symptomatic therapy, not etiologic, in the sense of the specificity of penicillin for paresis. As tranquilizing drugs, they bring about sedation without narcosis or hypnosis; sedation without the danger of addiction.

2. They can quiet excitements of all types: acute and chronic psychotics, especially the manic, the excited schizophrenic, the frenzied toxic state

continued on next page

*Presented at the meeting of the Rhode Island Society for Mental Hygiene, at Providence, Rhode Island, November 21, 1955.

and the agitated senile. They may even be life-saving in these cases, but probably not more often than barbiturates used to be.

3. They can improve the ward atmosphere—the social atmosphere, especially in senile wards which certainly is necessary. Restraints and seclusion rooms are reduced in number, all of which improves the morale of nurses and attendants.

4. The behavior disorders in children can be improved—there is more uniform agreement among the investigators that the aggressive child is more cooperative and less apt to "act out" his hostile impulses.

5. Fewer electroshock treatments are necessary for the excited chronic patient in order to improve ward conduct.

6. Fewer lobotomies have been performed since the advent of these drugs.

7. The discharge of some chronic patients from mental hospitals has been facilitated, but there is no uniform agreement as to the percentage and perhaps not more than 5%.

8. A certain number of patients can be kept out of mental hospitals and carried along in out-patient facilities—what percentage we do not know.

9. The drugs are considered aids in psychotherapy, helpful in encouraging a patient to seek out therapy for himself by quantitatively reducing his anxiety. This is still a debatable point.

10. These drugs can also cause side reactions and a small percentage of serious complications, like jaundice and agranulocytosis. They may even produce depressions.

What the "Miracle Drugs" Cannot Do

1. They cannot cure a single case in the sense of full restitution, without symptoms and with complete insight.

2. They cannot effect the excitement of every excited patient.

3. They cannot take the place of all previous treatments in psychiatry: e.g., psychotherapy, insulin shock therapy, electroshock therapy.

4. They cannot help in depressions—the drugs have no euphorizing effect.

5. They cannot reduce the number of schizophrenics to come, nor the future manics, depressives, paretics, arteriosclerotics or seniles.

6. They have very limited value in the psychoneuroses and are of no value in the personality disorders, such as criminalism, alcoholism, or drug addiction. They may help in the excitements or the withdrawal periods associated with the latter two.

To summarize, these drugs are not going to spell the doom of psychiatry; sadly enough, one out of each dozen of our citizens will require mental hospital care before he dies.

Electroshock Therapy

Electroshock therapy, introduced in this country around 1940, is another form of special treatment that is symptomatic therapy and not etiologic. It has beneficial short-term effect and shortens the hospital stay, even preventing hospitalization, of many patients. For depression, whether manic depressive psychosis, reactive depressions, involutional melancholia, or depressive aspects of organic psychoses, electroshock is effective in the majority of cases. The best indication for electroshock is involutional melancholia with the prospect of a remission rate of 85% in a period of three months. Compare this with the prognosis in involutional melancholia prior to convulsive therapy: 50% got well after hospitalization of two years or more, 25% remained chronically ill, and 25% died, many by suicide. The manic phase of manic depressive psychosis and the acute excited schizophrenic also respond to electroshock but not as uniformly.

Personal Experience

Permit me to make more meaningful this topic of the use of the newer drugs by referring to my daily clinical experience. In my private practice during the course of one recent week, more than half of my twenty-eight (28) different patients received sedation of some type. Chlorpromazine and reserpine were prescribed for seven (7) patients: three drug addiction problems, two schizophrenics and two psychoneurotics. I felt that these drugs had particular value as non-narcotic, non-habit forming sedatives. They actually constituted a substitute for previously used barbiturates, but I did not feel they had special value in psychotherapy over and above the use of barbiturates.

On my service in the psychiatric department, Philadelphia General Hospital, for the treatment of acute psychiatric problems, over half of my patients receive either shock therapy or these newer drugs or both. The chief value of the drugs is in their tranquilizing effect, helpful but not specific, in the excited patient due to any cause, particularly in the toxic deliria. A few patients have improved sufficiently directly due to the use of these drugs, but thus far there has been no effect on the admission rate or discharge rate at this overcrowded municipal hospital division.

In my experience as a consultant at a private mental hospital, the Pennsylvania Hospital for Nervous and Mental Diseases, the drugs are quite useful as tranquilizers, replacing the previous sedatives. No cures have been reported, although an occasional good result has been seen in schizophrenia. The best effect has been on the senile wards which have become quieter and where morale has been improved.

I recognize that my experience contrasts somewhat with that of many reports in the literature.

I also recognize that a large number of papers have been written by a few authors, particularly the reports on reserpine. It is my impression that we are still in the stage of enthusiasm regarding these drugs and must await more accounts of other investigators' clinical impressions before a final evaluation.

SUMMARY

1. The newer tranquilizing drugs have a place in modern psychiatry as symptomatic therapy. Their chief value appears to be in the severe and moderately ill psychotics, either acutely excited or chronically agitated. Hospitals will be improved in management and morale, but not census-wise. In the out-patient departments the greatest use will be for the aggressive child.

2. Electroshock therapy has an established place in the psychiatric armamentarium. It is specific in the treatment of the symptom of depression, best in involutional melancholia, also of value in the excited states.

3. Neither electroshock nor the newer drugs will cure a mental illness—both constitute symptomatic but not etiological therapy.

4. They will shorten the period of illness and shorten the hospital stay.

5. They will not empty out the mental hospitals.

6. They will not prevent future psychotics or neurotics.

7. They have no specific value in psychoneuroses.

8. They have no specific value in personality disorders.

9. They will not take the place of psychotherapy.

10. They have not spelled the millenium in psychiatry.

In conclusion, permit me to express my gratitude for this opportunity to return to Providence and for this chance to contribute toward this ambitious, worthwhile program.

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UNDESCENDED TESTIS

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five years of age. Two types of treatment are advocated: large doses of hormone for a short period of time, or small doses extended over a longer period. Deming[3] selects an age period of five to seven years, the optimum age being the fifth year. He recommends Follutein-S—250 international units administered intramuscularly three times a week for a total of 3,000 units.

Prentiss[9] advocates that chorionic gonadotropins (Antuitrin-S, or Follutein) be administered just before puberty (i.e., tenth to twelfth years), the dosage being 300 to 500 international units given intramuscularly two to three times weekly, for a total of 3,600 to 9,000 international units in each of a maximum of two courses. In contrast to this type of therapy, Robinson and Engle[4] recommend 4,000 to 5,000 international units of chorionic gonadotropins daily for three days. If no change occurs in a week to ten days, operation is advisable. At the present time I prefer the latter treatment as fewer side effects, such as precocious development or precocious puberty, develop.

I will not elaborate in detail as to the surgical technic. A hernia which is usually present must be repaired. It is of prime importance to free the testis and cord from all adhesions to the adjacent structures particularly to the peritoneum of the processus vaginalis. During this phase of the operation, care must be exercised to preserve the blood supply of the testis or atrophy will ensue. Unless all adhesions are severed the testis cannot be placed in the scrotum without tension. I likewise believe the testis should be fixed in the scrotum to prevent retraction.

Attachment of the testis to the fascia of the thigh is at times a useful procedure to prevent retraction. In the majority of instances by careful dissection the testis may be placed in the scrotum to permit normal development.

CONCLUSION

1. Cryptorchism is a fairly common congenital anomaly.

2. The pathological result of imperfect descent of the testis is the failure of the spermatogenic tubules to mature and failure of spermatogenesis ensues.

3. The danger of malignancy developing in an imperfectly descended testis is not an indication for orchiectomy.

4. It is generally accepted that surgical intervention, i.e. orchiopexy, should be advocated if endocrine therapy fails.

5. The preferable age for operation is before the fifth year.

6. Testicular biopsy should be performed at the time of orchiopexy.

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SURGICAL TREATMENT OF ULCERATIVE COLITIS*

JOHN H. GARLOCK, M.D.

The Author. *John H. Garlock, M.D., of New York City. Clinical Professor of Surgery, Columbia University; Senior Surgeon, Mt. Sinai Hospital, New York.*

I THINK THAT we can accept the truism that ulcerative colitis is probably one of the most difficult diseases of the gastro-intestinal tract to treat, especially from the surgical standpoint.

A great deal has been written in recent years about the surgical therapy of this disagreeable, and in many respects, terrible disease. There is apparently an increasing number of surgeons who are most radical in their thinking about the indications for surgical treatment and who recommend surgery very often in the early stages of ulcerative colitis.

A second group of physicians feels that conservatism should be continued until the last minute and that the so-called ileostomy life is the worst thing you could offer a patient.

Third, there is a small group who feel that the treatment of ulcerative colitis should be along psychiatric lines.

We have an experience of over twenty years with this disease, and we have come to our present opinion that there must be some rationalization of the treatment of ulcerative colitis, based on a number of factors.

I think it is important to understand some fundamental things before we can talk about surgical therapy.

It is, of course, a disease of completely unknown origin. It attacks mainly young people. It is particularly prevalent in large urban centers. It is very unusual to see ulcerative colitis in the farm groups.

There is no question about the fact that there are definite emotional disturbances in almost all of these patients. This is given as the classical example of the so-called psychosomatic disease.

Now, there are a number of things that are important to stress. In the first place, ulcerative colitis is characterized by spontaneous remission and exacerbation. The patient may be desperately ill with ulcerative colitis and for some unknown reason a sudden crisis takes place, and the patient gets well and may remain well sometimes for many years before the next attack will come.

What is more important is that during the acute episode or the subacute episode, the X-ray film may show extensive damage to the bowel, and yet in the interval there may be almost complete restitution to normal.

The second characteristic of the disease is the complete unpredictability of the response to a presumed specific remedy given for treatment. I have in mind any number of remedies that have been recommended over the years, where the cause and effect leave great doubt.

I am reminded of an incident that occurred (and I can cite many similar ones) in our hospital ten or twelve years ago. This concerned the illness of a young man of eighteen who was ill with ulcerative colitis. Every conceivable remedy was tried. He had been running a septic course for a period of four weeks. One evening the assistant resident went to his resident and said:

"That boy back there wants to have a salami sandwich for dinner. Is it all right with you if I go out and get one at the corner delicatessen?"

He said: "We've tried everything else; we might as well try that."

So the assistant resident went out and got the sandwich, and within forty-eight hours, the temperature dropped to normal and he had a spontaneous remission.

I cite that story to indicate the unpredictability of the response to a specific remedy. Of course, the sandwich had nothing to do with it, but something happened to the boy, causing the sudden remission of the disease.

You must remember that ulcerative colitis is pathologically essentially a mucosal disease in contradistinction to enteritis. After the initial hyperemia of the mucosa, superficial mucosal ulcers form to be followed by secondary infection from the bowel content. Then there begins a constant struggle between the processes of destruction and the processes of repair. The repair processes involve mainly the sub-mucosa and the muscularis, so the bowel is converted finally into a rigid tube,

*Presented at the Interim Meeting of the Rhode Island Medical Society, at Providence, R. I., October 26, 1955.

composed of scar tissue and many coalescing ulcers, separated by dirty granulation tissue constantly exuding pus and blood, and the formation along the edges of the ulcers of the so-called inflammatory pseudo-polyps.

I have picked out a number of slides to show you. I disagree with what Doctor Welch had to say about the X-ray diagnosis of ulcerative colitis in the early stages, because I think that with careful mucosal pattern studies, the radiologist can demonstrate the superficial ulcerations in the colon, and this is an example of what I mean.

This is another example of ulcerative colitis, with marked foreshortening, which is characteristic of the chronic case, and the narrowing of the descending colon and sigmoid.

Here is another example of the marked stenosis that may occur in the presence of long-standing ulcerative colitis. I am not convinced, from our experience, that all ulcerative colitis starts in the rectum and progresses to involve the rest of the colon. I think that in the vast majority of such instances, ulcerative colitis is a universal disease, and the reason it is recognized in the rectum is because that is a part of the large bowel which is open for inspection by sigmoidoscopy to the rest of the large bowel where minimal mucosal unadvancement may be difficult to demonstrate by the usual radiographic methods.

Among the complications of ulcerative colitis, especially the right-sided variety, are the lesions, joint involvement, and the eye changes.

Here is an example of a physician who had universal colitis; he had been under the care of many specialists for years, who tried to heal extensive ulcers on the dorsum of both feet and ankles.

Now this presented a very peculiar ulceration. It resisted all forms of therapy. It was only after he began to talk about his diarrhea that the colon was suspected. After ileostomy and total colectomy, both feet healed spontaneously in a very short time.

You all know about the complications of the joints, the joint effusions, the painful joints, and the swelling of the periarticular tissue, which may be considered as one of the pathological complications of ulcerative colitis and which can be cured only by removal of the diseased bowel.

One of the complications of ulcerative colitis is the penetration of one of the ulcers through the entire thickness of the wall and the formation of a pericolonic abscess. This will reach the surface of the abdomen, usually on the left side, and will be followed by a fecal fistula, after the surgeon draws the abscess.

One of the most frequent pathological complications of ulcerative colitis is the development of the so-called inflammatory polyps. I emphasize this complication because of the increasing incidence of carcinoma in this particular pathological setup.

In approaching the question of the surgical treatment, it is our opinion that this should be done on the basis of a group study, rather than on the individual opinion of the surgeon alone. We have had a study group in our hospital over the past twenty years, consisting of the department of medicine, the gastroenterologists, the radiologists, psychiatrists, and the surgeons, and the Social Service Department.

When should a patient be operated upon?

I might tell you that of the 250 or 300 patients with colitis coming into our hospital every year in the various departments, only 20 to 22 per cent of them are operated upon. The vast majority can be treated medically. Of course, they are not severe enough to require operation.

Over the years, we have gradually come to the following plan: first, treat the pathological complications of the disease; secondly, operate to save life, if it is of the fulminating variety; third, you must remove the colon in the chronic cases that have been going on for many years, with irreversible changes in the bowel and where the patients have become chronic invalids. In the latter group, the rehabilitation that eventually takes place constitutes one of the remarkable things in gastrointestinal surgery; fourth, we believe a positive indication for surgical intervention is the presence of polyps, because of the high percentage of carcinoma in this group.

Now, as to the pathological complications, we have:

1. Peri-colonic abscess.
2. Multiple fistulae in the peri-anal region or rectovaginal fistulae. Fistula in ulcerative colitis is very uncommon, as compared with regional enteritis, where internal fistulae between organs are more frequent.
3. The occurrence of severe hemorrhage. This may have to be a life-saving measure.

The second general indication for surgical treatment is concerned with the irreversible changes that occur in the bowel as demonstrated by X-ray examination and prolonged observation.

Then there is the problem of polyposis.

Then, there is the fulminating variety of the disease.

Now, in the surgical therapy of this disease, there has occurred a change in the last four or five years. Prior to that time, the surgeon would be called in, especially in the acute variety of the disease, as a last resort. It took us many years to convince the medical men to call us in at an earlier stage of the disease, so as to be able to reduce the mortality of ileostomy alone. I remember in the

continued on next page

early days of our therapy of this disease, coming down many nights to do an emergency ileostomy. The mortality in that group was over 20 per cent. But, since we have changed our approach, the mortality has dropped to under 5 per cent, including the acute variety.

The plan in the early days was to do the ileostomy first, followed in three to six months, after the weight gain of thirty to fifty pounds had taken place by a subtotal colectomy in one or two stages, the final stage was an abdominal perineal resection, if the disease in the rectum required it.

Over the last five or six years, there has been a change in this regard, due to the fact, I think, that we now have the antibiotics, and we have a clearer appreciation of the need for removing a diseased organ in one stage rather than in multiple stages. As a result, the surgical radicality that is sweeping the country today now advocates the total jobs in one stage in every patient who comes to operation. Perhaps patients vary around the country, but we simply do not see too many people who can take this radical surgery.

The occasional chronic ulcerative colitis patient who has to be operated upon will be able to stand such a procedure. We have done a few of them. But, I am doing a woman tomorrow who has been violently ill for two weeks; I was called in to see her this morning, and I would be very loathe to subject her to a one-stage procedure of this magnitude. She has to have a subtotal colectomy. I don't think that ileostomy alone will do her any good because she is bleeding. So that we will do an ileostomy and subtotal colectomy in one stage, and do the abdominal perineal at a later date.

We are doing more now than ever before, the one-stage colectomy and ileostomy operation. But, I still think that there is a place for ileostomy alone.

I lost a little boy of fourteen with severe ulcerative colitis, who had a marked protein and electrolyte deficiency; we took two weeks to correct these defects before operation upon him. I did a subtotal colectomy and ileostomy in one stage. He died. I am sure that if I had confined myself to a simpler procedure like an ileostomy alone he might be alive today.

I cannot leave the subject of the surgical therapy of this disease without indicating to you that perhaps one of the reasons why the medical men have been so loathe to permit surgical treatment is because of the many complications that very frequently follow the ileostomy itself, exclusive of the colectomy.

Ileostomy is heir to all sorts of complications. To mention a few there are major skin excoriations, prolapse, fistula, and severe electrolyte imbalance which may cause the patient's death within a matter of a few hours. There is also the so-called ileostomy dysfunction, due to obstruction. Also, retraction and stenosis. Something new has been added, the development of enteritis, and that is serious and unpredictable. The increasing frequency of this latter complication may change our whole concept of the treatment of ulcerative colitis in the future.

Now, we have eliminated most of these by a process of prophylaxis and prevention. Over the past year, we have developed an operation approach to the formation of the ileostomy which will be published shortly. I believe this operation will eliminate most, if not all, of the complications mentioned.

If you plan to do an ileostomy colectomy in one stage, this technique is employed. One makes a long, left rectum incision. The abdomen is opened and the terminal ileum is inspected and transected approximately 12 to 18 inches proximal to the ileocaecal valve. The distal end is closed over with suture. The proximal end, which will form the permanent ileostomy, is also closed over with suture, and the colectomy is proceeded with.

We believe very strongly, on the basis of our experience with now close to 400 cases, that it is important in the vast majority of these cases to close the retro-colic area by careful approximation of the peritoneal flaps.

Our incidence of obstruction has dropped from 40 per cent to 5 per cent, and I attribute it to that one maneuver alone.

After the colectomy has been performed, the lower sigmoid is closed by a clamp, and must be exteriorized for drainage of the contents of the remaining diseased bowel, which is still inside. After that has been accomplished, a button of skin is excised from the abdominal wall, which has been carefully determined beforehand, and marked with indelible ink. When one chooses the site for the permanent ileostomy, one must take into account the subsequent great weight gain and must also have no scarring where the subsequent bag is to be applied. Third, it must be located where it can be taken care of easily by the patient, and not be noticeable, after the patient is fully clothed. We feel that the most desirable place is in the right lower quadrant.

I agree entirely with Turnbull and Crile about their theory of the cause of ileostomy dysfunction. The peritoneal surface of the exteriorized ileum, immediately is bathed by the fecal discharge, setting up a serositis. The ileal end gradually becomes thickened, rigid, mal-functioning portion of the ileum from the skin surface, out. I don't believe Turnbull and Crile went far enough in their description. I think that the serositis exceeds into the abdomen. We know that many of our complications are due to obstruction. The percentage

of our original group was 40 per cent. To aid overcoming this complication, we do a modified noble-plication on the terminal two feet of ileum. In doing this we place the bowel in the position of our choice, thus preventing the irregular adhesions which form after the serositis develops.

To prevent prolapse, we suture the cut edge of the mesentery to the parietal peritoneum as originally described in 1938.

Now, to prevent, the external serositis, instead of using the complicated operation described by Turnbull and Crile, we use a much simpler one, that of Brooke, which is a complete eversion of the full thickness of the wall and the suturing of the edges of the ileum to the edges of the circular skin excision.

We have been very much impressed with this operation. I might tell you that we now have a series of twenty-three successive cases. There was one mild example of ileostomy dysfunction, which lasted for twenty-four hours, and I am not so sure it was ileostomy dysfunction. And we had one boy who died of intestinal obstruction.

Here is a photograph of a patient taken on the operating table. Here is the exteriorized sigmoid and the clamp closing the end. The next step is the immediate application of an ileostomy bag, made of cellophane. It is placed on the patient at the time of the operation.

Here is a photograph of an ileostomy taken ten days after operation. And here is the ileostomy taken three months after the operation. Notice the absence of skin excoriation, and secondly, the projection of a portion of the small bowel which will fit accurately into the bag, and third, we have permitted enough room for the application of the flange of the bag which must fit on the smooth surface.

I believe that this type of ileostomy may be the answer to many of the problems which have plagued surgeons in the past.

I have one more slide. We went over our group of surgically treated ulcerative colitis patients a few years ago, to try to find the incidence of carcinoma. These are interesting figures:

In 137 cases of ulcerative colitis, treated surgically, there was an incidence of carcinoma of 3.9 per cent; in the universal group. These were all young people. And in patients with the disease over twelve years, the incidence was 36 per cent. In patients with the disease in the rectum for over twelve years, the incidence of carcinoma was 43 per cent.

To be sure, in the last column the numbers are small, but there are two things which are very significant; one is the fact that the carcinoma develops in people at an earlier age than carcinoma in the average population.

Secondly, this is the most virulent form of carcinoma of the large bowel.

We have only one survivor in our group, and that patient had one excision of a metastatic nodule in the vagina; she is now going for nine years.

That is very important to remember in the surgical consideration of the therapy of ulcerative colitis.

UNDESCENDED TESTIS

concluded from page 143

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PHYSICIANS SERVICE PROGRESS IN 1955*

CHARLES J. ASHWORTH, M.D.

The Author. *Charles J. Ashworth, M.D., of Providence, President, Rhode Island Medical Society Physicians Service; Past President, The Rhode Island Medical Society.*

TIME has been defined as a measure of change. This Seventh Annual Meeting of the Corporation of our Rhode Island Medical Society Physicians Service may well note the implications of that definition. One is emphasized by my very presence in the position of president, succeeding to the tasks so well accomplished by our late leader, Doctor Joseph C. O'Connell, whose sudden death after more than five years of outstanding achievement for this Corporation, for the medical profession, as well as for the people of Rhode Island, left a challenge.

We pause in respect to his memory.

Another portentous as well as implicatory aspect of this measure of change, delineates itself in a twofold projection, retrospective and anticipative. The progress of our Plan throughout 1955 as it relates to numerical increase in enrollment, and the monetary factors of income, expense, and reserves, are detailed in the secretary's report. Suffice it is to say here that our enrollment is the second highest per capita in the nation and our administrative costs among the lowest.

Two dates are significant, March first and October first. On the former date, with the approval of the insurance commissioner of Rhode Island, Mr. George A. Bisson, the medical benefits of the contract were extended to cover services to a subscriber from the third day of a hospital admission, where prior to that date coverage started with the fourth day. Increase in payments to physicians in medical cases was also extended to the limit of the indemnity schedule, $225.00, or fifty-six (56) days in certain disease categories.

The latter date was one of even greater moment. The need for increased revenue was recognized by the insurance commissioner, and an increase in premium rate permitted the addition of X-ray benefits to our subscribers. This X-ray benefit after many months of study, is one of, if not the most liberal offered by any prepayment plan in the country, indemnifying X-ray costs according to a special schedule, without limitation in any contract year. Our first three months' experience indicates that the plan should, without abuse, operate successfully within the limits of the fund allocated to this benefit.

Also of this date, it should be noted that certain new regulatory measures were imposed by the insurance commissioner:

1. 5% of income must be added to statutory reserve until it reaches $1,000,000.00.
2. No additional indemnities shall be made to the present schedule without prior consultation with the insurance commissioner.
3. If the total of the statutory and other reserves shall at the end of any calendar year exceed five months' average incurred benefits, the excess may be returned to subscribers by passing a month's assessment.

A few items identified with this measure of change in 1955 are worthy of mention. An increase of more than 26,000 subscribers raises our coverage to approximately 61% of the eligible population of this state. Fifty-five additional firms have purchased Physicians Service in the past year, raising the total to 776.

These two factors alone, explain in part at least, how $4,378,012.00 was paid to physicians in 1955, with an increase in income of $776,126.00 of which $350,829.00 was added to our total assets, and total reserves increased by $156,475.00.

Against this gain our operating expenses increased by $39,600.00, which percentage-wise, is a reduction of 0.2% over the preceding year. Similarly, the percentage of claims funds was reduced by 0.6% despite the addition of X-ray and EKG benefits available during the last quarter of 1955.

Lacking thirty-five cases of a total of 124,000 a new peak was reached last year, approximately 25% more than in 1954, including 843 more maternity cases.

Annually and justifiably, we look with pride to the accomplishments of a year just finished. This year is no exception. The base from which our current satisfaction derives, however, has widened appreciably in the past twelve months as I have indicated.

*An address to the Corporation of the Rhode Island Medical Society Physicians Service at its Seventh Annual Meeting, at Providence, Rhode Island, January 25, 1956.

You are engaged in the operation of a $5,000,000.00 Corporation. Considering that over 100,000 claims were processed last year, one gains some concept of the administrative expanse that must necessarily keep pace with this degree of growth. Additional space, help and equipment were natural sequels for the continued efficient operation of our Plan by Rhode Island Hospital Service Corporation. Certainly to Stanley H. Saunders, executive director, Edgar H. Clapp, assistant director, and their entire staff, I am most happy to express on your behalf our thanks for these administrative achievements.

A very special word of gratitude may I express for you to the non-medical members of your board of directors, each of whom has given unstintingly of his time to the deliberations and committee work involved in securing and protecting the interests of, not only the citizens of this community for whom the Plan primarily exists, but also for the doctors.

I have long felt, and on previous occasions said, that in the Claims Committee, more so than in any other area, can the true pulse of the Plan be felt, its curve charted, and vitality evaluated. Consequently, under my aegis, this committee has been numerically increased to ten members, two of whom meet on the first three Thursdays of each month, and the entire six meet on the fourth Thursday to adjudicate claims, the responsibility for which no two men should be asked to assume. The manner in which this schedule has been worked out leaves no two men sitting together alone twice in one year; thereby not only broadening the experience of the new members as well as the older members, but diversifying that responsibility which for the past five years your Claims Committee assumed and discharged with a minimum of complications.

Supplementing this claims arrangement we now have a group of six consultants consisting of men specialized in their fields but in whose areas only a small percentage of claims develop. They cover anesthesia, ear, eye, nose and throat, pediatrics, obstetrics, plastic surgery and neuro-psychiatry. We have already utilized these men in certain instances to expedite settlement of claims in these specialties.

It so happens that four months in each year have a fifth Thursday. At these approximate quarterly meetings the more difficult problems in the claims field are settled by the entire committee, together with any or all of the consultants whose special advice is needed.

One additional adjunct designed to promote a more direct channel between the county societies and Physicians Service has been the establishment of District Medical Society Liaison committees. Six of the seven county societies have already submitted the names of members appointed to represent them and through whom immediate approach to the board, or any of its officers of committees, is possible without recourse to a regular or special meeting of the county medical society. This should prove especially effective when the element of time might militate against the expeditious solution of an urgent problem.

Embarked as we are, upon a voyage into this little known sea of insurability, the arc of prepaid medical care in our locale encompasses only a small angle of this horizon. The immediate future, to say nothing about our remote future, is teeming with new avenues of approach to meet constantly increasing demands being made upon us to furnish coverage beyond the basic limits our plan now provides. Major medical expense insurance is the immediate project of a committee of your board of directors, whose investigation of this phase of coverage was temporarily interrupted by the demand for and development of X-ray benefit. This study will embrace coverage in categories of disease that Physicians Service was never, nor is now, constituted to offer. Several plans whose experience antedates our own are now pioneering in these fields, and by their experience we hope to profit before asking public subscription to, and your professional support of, a development that will necessarily have to be consistent with and adherent to the fundamental precepts of insurability.

On the occasion of his elevation to the presidency of the American Medical Association at Atlantic City last June, Doctor Elmer Hess in his inaugural address on a program called *Medicine's Proclamation of Faith* said: "Faith is something bigger than we are." Long before the utterance of this dictum by Doctor Hess, your Plan, through the instrumentality of the board of directors, set up all the conceivable safeguards to secure and preserve this philosophy of faith, and will so continue.

We trust solely in the hope that these efforts will elicit a degree of confidence on the part of the profession and the public; that will stimulate us, as entrusted servants of a truly humanitarian endeavor, to the attainment of those ends that will completely satisfy any and all elements of this crusade for better health protection, out of which the Plan was conceived and born.

PUBLIC ATTITUDES ON MEDICINE

Highlights of Major Findings of the Recent Public Opinion Survey Sponsored by the American Medical Association

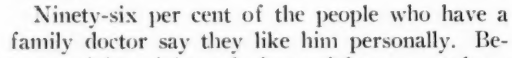
AMERICANS' FEELINGS about their doctors and doctors in general have been reported in a nationwide survey by an independent opinion and market research firm. The study, sponsored by the American Medical Association which released its report last month, was undertaken in order to find out what might be needed to improve doctors' services.

From it emerged a picture of what people like about and expect from their doctors: sympathy, patience, and understanding, rather than guaranteed cures and "wonder drugs." What they criticize is a matter of time and economics, not of personality or ability.

Major items shown by the survey are:

1) Most Americans have their own family doctor; 2) most of them like him, and like doctors as a group; 3) people's opinions gained from their own experience differ from those based on hearsay or other sources; 4) doctors are more critical of themselves than are other people; 5) when people criticize physicians, it is largely for the cost of care; they do not, however, think doctors are trying to "get rich quick"; and 6) they are evenly split for and against "sliding scales" of fees.

Ninety-six per cent of the people who have a family doctor say they like him personally. Between eighty-eight and ninety-eight per cent have high opinions of his intelligence, capability, dedication to humanity, and personal interest in patients. Their most unfavorable comments are that he thinks he is always right, and is hard to reach for emergency calls.



Americans have a good opinion of doctors generally; ninety-three per cent of all those surveyed say doctors as a group are "likeable." But people are more inclined to think in impersonal terms and to use different standards in judging doctors other than their own. The proportion of favorable attitudes is lower, and denial of faults less emphatic, when they speak of doctors they do not know personally. About doctors in general they are critical mostly of fees, coldness, impatience, lack of frankness, unavailability, and incompetence.

In personal interviews with 4,000 people during 1955, surveyors got the answers to questions based on preliminary discussions with the public and with physicians, and from current literature. The survey was conducted by Ben Gaffin & Associates, Chicago, with interviews by 289 surveyors from United Interviewing company, an associated group.

Although the A.M.A. approved the questionnaires after completion the survey firm said in its report "it is to be emphasized that the public, individual doctors, and the research agency established the issues."

* * *

Interviewees were selected so that the proportion of people from various age, economic, geographical, and other groups matched the proportion of such people in the total U. S. population.

Among them were 3,000 private citizens, 500 practicing physicians, 100 editors, commentators, and columnists, 100 attorneys, 100 registered nurses, 100 registered pharmacists, and 100 non-physician executive secretaries of state and county medical societies. Questions about general public attitudes were asked only of the 3,000 individuals; the special groups were asked largely about professional or organizational matters. Doctors were asked their feelings about themselves and other doctors.

Here are some major results

I. Five-sixths (82 per cent) of Americans have family doctors. Ninety per cent of rural farm dwellers have their own physicians and high percentages also are found among white collar workers, middle-aged, middle-income, college-trained people, and central state residents.

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The RHODE ISLAND MEDICAL JOURNAL

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WE DON'T LIKE IT

THERE ARE MANY aspects of the prominence given to medicine in this modern world that most of us doctors do not like. We suppose it is safe to say that very little of the modern popular medical writing for the public is really pleasing to our best minds. THE NEW ENGLAND JOURNAL OF MEDICINE recently called attention to the fact that, although physicians in Massachusetts officially considering the poliomyelitis situation had expressed a carefully considered opinion, a popular sports writer did not hesitate to tell them in no uncertain terms that they were all wet.

One of the things which we particularly dislike is the way in which almost any manufacturers of patent medicine inform the public in their advertisements that everything they say is based on the opinions of the medical profession. The medical profession is held responsible for the widely publicized statement of alkali manufacturers in Indiana that their products will handle the common cold. We doubt if most of the medical profession feel that way. Perhaps most of us do feel that large doses of synthetic vitamins help out most everybody in America, but we doubt if the manufacturers of vitamins can find that stated very categorically in the best writings.

One of the things that we believe is especially bad is the poll of American cardiologists, which has been conducted by the UNITED STATES NEWS AND WORLD REPORTER, regarding President Eisenhower's fitness for another term. Careful physicians would not put themselves on record regarding that problem. In the first place it is not to be answered by any *yes* or *no*. Any statement that was worth the paper it was printed on would have a discussion of some length. But of course we are all careless people. Lots of questionnaires come to our desks. Some of them are decidedly worthwhile and perhaps we conscientiously answer a good many of these because we want to be helpful. If we are really careful, however, we know perfectly well that few of us are in any position whatever to pass upon President Eisenhower's problem, even though we are particularly well-informed cardiologists. Our guess is that this was an unusually cheap, bad piece of work. If eighty-five per cent of the men consulted report that President Eisenhower should not run again, we have a feeling that would be offered for a good monetary return to the Democratic organization, and if they reply the other way, the Republicans would be offered a piece of goods for value received. We are

continued on next page

pleased to hear that most of the medical opinions about this cheap piece of work have been derogatory and we are glad to add our little argument against it.

MEDICAL EDUCATION WEEK

In a national effort to dramatize the fact that the nation's eighty-one medical schools are enrolling and graduating more physicians and providing greater research facilities than at any time in history, Medical Education Week has been established for April 22-28. During this seven-day period American medicine, utilizing every media of communications, will try to tell the public at large about its wonderful medical colleges.

Such facts as the following will be translated in positive terms for all people to understand, and thereby appreciate the schools' selfless contributions to the healthier life for all Americans.

Enrollment in 1954-55 totaled 28,583.

Graduates in 1955 were 6,977, up more than 2,400 since 1930.

One new school — Miami — graduates its first class in 1956.

Three schools formerly two-year schools will graduate their first classes of a four-year program within the next two years.

Three completely new schools—Albert Einstein, Seton Hall, and the University of Florida — will graduate their first students in a four-year program in 1959-1960.

Forty-two schools are privately endowed; thirty-seven, state, and three, municipal.

From the viewpoint of the future of medical education in this country the Medical Education Week will also emphasize some of the things that are currently going on, such as constant analysis of programs of administration, curriculum revision, contributions to medical knowledge through research, and evaluation of the "pros" and "cons" of specialization trends today and the ways and means of developing programs to meet the current needs and those in the immediately foreseeable future.

The complete story cannot be told in one week. To the physicians in Rhode Island and in every other state goes the assignment to keep constantly before the American people the achievements of our medical schools, and the importance of general support by everyone to assist the schools in their expansion and continued progress.

"I WANT A DOCTOR"

The Medical Bureau of the Providence Medical Association, the executive office of the Society, and the librarian, hear that call often during the year.

The task of securing a physician on short notice to answer the emergency call is not any easy one. Of late it has become quite a task.

It is quite true that many of these calls may be termed needless, annoying, and certainly non-emergency demands. Last year this JOURNAL published a study of the so-called emergencies reported over a period of three months that revealed clearly that the layman cannot be expected always to determine what is or what is not a true emergency.

The Providence Medical Association's operators do a fine job in screening the calls that come through their switchboards, and a physician is not alerted unless the caller gives reasonable indication that the services of a doctor are imperative — from his viewpoint at least. Often many of the emergencies are resolved by a call from the physician whereby he is able to reassure the patient, or prescribe sedative procedures to be followed until daylight hours if the call is made in the night hours.

The fact remains, however, that the physicians are the only ones who can render medical service. In Providence the Association has as fine a secretarial answering service as there is in the nation; but its effectiveness depends upon the physicians making themselves available to answer their share of the emergency calls.

One misunderstanding that should be corrected is the idea that specialists, particularly new members of our component societies, endanger their professional specialty standing by accepting general practice work. No national rating board has ever proposed that aspirants for specialty approval by it should refrain from handling local emergency medical services, such as we have mentioned above.

If every member of our various county and district medical groups accepted his share of the responsibility, the task of guaranteeing aid to those who truly need it would be minimal, and it even would create no burden in spite of the added load of calls from those who fail to appreciate the true meaning of emergency medical service.

SCIENCE FAIRS

The action of the Society in voting to award prizes to the best medical or public health exhibit in both the senior and the junior high school groups at the annual Rhode Island Science Fair is to be commended.

For some time now there has been increasing popular interest in the sciences, and the development of fairs to stimulate students to study science has gained momentum throughout the nation in the past five years.

It was time, therefore, that physicians should do their part in attracting new talent to the various medical and related sciences. The local prize is but the start for the student in Rhode Island who wins the award, for if he (or she) is also one of the

two fortunate ones to be sent from here to the national science fair in Oklahoma City, the possibility of winning an American Medical Association prize is in the offing.

The A.M.A. plans to present the high school student with the best medical exhibit a special citation, and he (or she) will be a guest exhibitor at the A.M.A.'s scientific session in Chicago the second week in June.

The Rhode Island Fair will be held at the Hope high school in Providence on April 1, 2, 3, with approximately 800 students expected to present displays in the competition. Five winners will go to the New England fair, and two of the group to the national. In addition, the Committee on Arrangements for the annual meeting of the Society plans that the Rhode Island winners selected by a special committee of physician-judges, headed by past president Dr. Herman A. Lawson, will present their exhibits at the Medical Library, May 1, 2, 3, at the State Society's 145th annual meeting.

PARKING RESTRICTIONS

Parking restrictions have to be imposed for the advantage of the majority of the public. The traffic problem in our metropolitan areas needs no delineation here; it is only too well known to every physician.

We take this occasion, however, to point out that the police departments in our larger cities, where there are many restricted parking areas, have been most sympathetic with the problem of the doctor who must make a medical call at a home on a street marked with such a sign as "No Parking, 8 to 10 a.m." True, physicians have been tagged for parking on such streets, and while actually making medical rounds. But the officer assigned the area may not have known the auto belonged to a physician, and even if he did, he is under obligation to carry out the traffic regulations.

The Society has issued to every member an official auto sticker that should be used *only* on the car that the physician drives while making medical calls. This sticker has no official status as an excuse to violate a parking regulation. It does help identify the car to the police as belonging to a physician.

Doctors might consider posting on their inside windshield a slip indicating where they are making the medical visit in the restricted area, and if possible indicating arrival and probable departure times. Otherwise, if tagged for violation the physician should communicate directly with the central police station, and make known the reason why he had to park in the restricted area. We feel certain that any police department head would adjudicate the matter fairly.

The cooperation of our police departments calls for equal cooperation by every physician. Parking in a restricted area for a medical call, emergency or otherwise, is one thing; parking there as a matter of personal convenience, or allowing members of his family to park in such areas because the auto bears an M.D. insignia, is another.

AN INVITATION FOR THE DOCTOR'S WIFE

If your husband is a Fellow of the Rhode Island Medical Society, you as his wife are eligible to belong to the Woman's Auxiliary. It is both your privilege and your responsibility to support your husband and the medical profession in this way.

It is sometimes difficult for us to reach each and every one of you, and so we extend to you here a cordial invitation to become one of us.

You will want to know what membership in such an Auxiliary means. First of all, it is a wonderful means whereby you become acquainted with other doctors' wives, and make new and lasting friendships.

Our work is also directed towards supporting community health and medical programs throughout the State. We also support nurse recruitment and scholarships for nursing.

Membership in the State Auxiliary automatically makes you a member of the National Woman's Auxiliary and permits you to participate in their program at the time of the annual session of the American Medical Association meetings.

Membership is not limited to physicians' wives alone. It is open also to a physician's widow.

We would be pleased to have you apply for membership to Mrs. Frederick A. Webster, 70 Greenwood Avenue, Rumford 16, Rhode Island.

PUBLIC ATTITUDES ON MEDICINE

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II. While two-thirds of these people once had other personal physicians than their present one, their reasons for changing doctors rarely include personality clashes or lack of faith in the doctor's ability. The most frequently given reason (by 19 per cent) is that the patient or the doctor moved. Only one-twentieth say they lost confidence and two per cent that they "found a better doctor."

III. Most people tend to think of their doctor as "someone special" and feel that today — even more than twenty years ago — it is important to choose the right man. Fifty-eight per cent believe it matters "a lot," giving as reasons "ability, training, and equipment" first and confidence or sincerity next. The 24 per cent who say it doesn't matter explain most often that doctors have the same education and qualifications.

IV. About eight of ten people think their doctor is "different." For their reasons, 32 per cent cite personal interest, sympathy, and kindness; 19 per cent competence, intelligence, and education; 17 per cent friendliness, personality, and manner; and nine per cent frankness and honesty. Small numbers mention availability, patience, understanding, acceptance of payment delays, and lower fees. None mention healing powers or use of wonder drugs, although those who say choice of physicians is not important do mention drug use as a factor.

V. Of those persons who have a personal physician, only one per cent do not like him and three per cent give qualified or no replies. Ninety-nine per cent say he is capable and 88 per cent "highly intelligent." Between 80 and 90 per cent feel their doctor has enough personal interest, is frank enough, and gives his patients as much time as they would like.

Complaints Denied

Most people, when speaking of their own doctors, deny complaints listed in a true-false questionnaire. For example:

I. Ninety-one per cent deny (5% agree) that their doctor thinks he is better than other people; 87 per cent say (6% deny) that he is as dedicated to serving mankind as he should be; 82 per cent deny (5% agree) he is too quick to recommend operations; 80 per cent say (15% deny) he is frank enough about their illnesses; 78 per cent deny (15% agree) he keeps patients waiting longer than necessary.

PEOPLE LIKE MOST DOCTORS *but*

1 in 8 thinks they charge too much

1 in 11 thinks { **they hurry you** / **they're impersonal** / **they're not frank**

1 in 17 thinks they're not available

II. Seventy-nine per cent deny (16% agree) he charges too much; 77 per cent deny (10% agree) he plans to get rich quickly; 78 per cent deny (13% agree) his charges have gone up faster than other living costs; 74 per cent deny (19% agree) he is hard to reach for emergency calls; 71 per cent deny (23% agree) that he has the idea he is always right; and 66 per cent deny (13% agree) that he makes too much money compared with his patients.

Only on three statements of complaint was there less than 66 per cent denial, but these three statements were not answered by about half the interviewees. They were:

Your doctor charges higher fees to people who carry medical insurance: 48 per cent deny, 39 per cent no opinion; your doctor splits fees on referrals to other doctors: 32 per cent deny, 57 per cent no opinion; your doctor gets commissions from druggists: 31 per cent deny, 52 per cent no opinion.

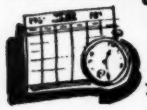
Most people give the same reasons for liking doctors in general as they do for their own physicians, with some exceptions. They attach more importance to friendliness and manner, healing and curing, dedication, and professional attitude than when describing personal physicians.

Given a chance to criticize, one-third have no criticism and 15 per cent "don't know" what they don't like about most doctors. Leading complaint, listed by 13 per cent, is "their charges and interest in money." Nine per cent mentioned each of these complaints: "don't take time and hurry you too much," "impersonal, cold, independent," and "not frank, speak half-truths, dishonest." Some of those listing dislikes say their complaints refer only to "some, not most" doctors.

NO 40-HOUR WEEK *for MY doctor!*

People's average estimate - 63 hours*

Their average estimate of his time devoted to charity cases- 1 hour out of every 8*



**Both estimates fit the facts*

RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

Report of the Seventh Annual Meeting of the Corporation, January 25, 1956

THE SEVENTH Annual Meeting of the Corporation of the Rhode Island Medical Society Physicians Service was held at the Rhode Island Medical Society Library, Wednesday, January 25, 1956. The meeting was called to order by the President, Charles J. Ashworth, M.D., at 8:40 P.M. The following members of the Corporation were in attendance:

Charles J. Ashworth, M.D.
Robert R. Baldridge, M.D.
Henry W. Brownell, M.D.
Alex M. Burgess, Jr., M.D.
Bertram H. Buxton, Jr. M.D.
Wilfred I. Carney, M.D.
Francis H. Chafee, M.D.
William B. Cohen, M.D.
Frank B. Cutts, M.D.
Michael DiMaio, M.D.
Peter C. Erinakes, M.D.
Charles L. Farrell, M.D.
J. Merrill Gibson, M.D.
Thomas L. Greason, M.D.
Edmund C. Hackman, M.D.
John C. Ham, M.D.
Hannibal Hamlin, M.D.
Robert C. Hayes, M.D.
Joseph A. Hindle, M.D.
Albert H. Jackvony, M.D.
Ernest K. Landsteiner, M.D.
James A. McGrath, M.D.
William S. Nerone, M.D.
Thomas A. Nestor, M.D.
Thomas Perry, Jr., M.D.
Arnold Porter, M.D.
William A. Reid, M.D.
Louis A. Sage, M.D.
William J. Schwab, M.D.
James J. Sheridan, M.D.
Henry E. Turner, M.D.
George W. Waterman, M.D.
Hrad H. Zolmian, M.D.

Also in attendance was John E. Farrell, Sc.D., Executive Secretary.

Address of the President

Dr. Charles J. Ashworth, President, read his annual report to the Corporation regarding the developments in the Physicians Service Program. This report is made part of the official minutes of the meeting.

Annual Report of the Secretary

Dr. Ernest K. Landsteiner, Secretary, read his annual report, copy of which was submitted to each member of the Corporation and copy of which is made part of the official minutes of the meeting.

Action: It was moved that the annual report of the Secretary be received and placed on file. The motion was seconded and adopted.

Annual Report of the Treasurer

Dr. Orland F. Smith, Treasurer, read his annual report, copy of which is made a part of the official records of the meeting.

Action: It was moved that the annual report of the Treasurer be received and placed on file. The motion was seconded and adopted.

Election of Members to the Board of Directors

The Secretary reported that the House of Delegates of the Rhode Island Medical Society had nominated to serve for a three year term until the Annual Meeting of the Corporation in 1959 the following:

Charles J. Ashworth, M.D., Providence
Albert H. Jackvony, M.D., Providence
G. Edward Crane, M.D., Providence
Ernest K. Landsteiner, M.D., Providence

Action: It was moved that the physicians nominated by the House of Delegates of the Rhode Island Medical Society be elected by the Corporation. The motion was seconded and adopted.

Adjournment

Dr. Ashworth called for any new business to be presented to the Corporation, and as none was presented he declared the meeting adjourned at 9:15 P.M.

Respectfully submitted,

ERNEST K. LANDSTEINER, M.D., *Secretary*

Annual Report of the Secretary

During the fiscal year 1955 the Board of Directors of Physicians Service held seven meetings to carry forward the many activities of the program. With the start of the year a revised Joint Operations Agreement with the Hospital Service Corporation went into effect and the Schedule of Indemnities was revised as regards many procedures.

The Board of Directors elected the following officers at its Annual Meeting in January, 1955:

Joseph C. O'Connell, M.D. ..... *President*
Rocco Abbate, M.D. ..... *Vice President*
Charles J. Ashworth, M.D. ..... *Treasurer*
Ernest K. Landsteiner, M.D. ..... *Secretary*

Re-elected as public representatives on the Board were Messrs. James R. Donnelly, Emil E. Fachon, Walter F. Farrell, John J. Halloran, Felix A. Mirando and George R. Ramsbottom.

On March 3, 1955 the Corporation and the community sustained a great loss in the sudden death of Doctor Joseph C. O'Connell who had been president of the Physicians Service Program from its inception. The Board elected Dr. Charles J.

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Rhode Island Medical Society Physicians Service
Comparison of Statistics—Years 1954 & 1955

	1954	*1955*	*Increase or (Decrease)*
Subscribers	442,777	469,147	26,370
No. of firms buying Physicians Service	721	776	55
Number of Participating Physicians	817	835	18
Claims Paid to Physicians	$3,707,803	$4,378,012	$670,209
Total Payments to Physicians Since Start of Plan	$10,784,560	$15,162,573	$4,378,012
Total Assets	$1,820,771	$2,171,600	$350,829
Total Income	$4,114,096	$4,890,222	$776,126
Total Reserves	$518,409	$699,754	$181,345
Operating Expenses	$249,817	$289,417	$39,600
Operating Expense — %	6.1%	5.9%	(0.2%)
Claims — %	90.1%	89.5%	(0.6%)
Number of Cases:			
Surgical*	57,781	64,800	7,019
Assistants*	10,419	11,586	1,167
Anesthetists*	23,079	23,811	732
Medical	7,861	10,300	2,439
X-ray & Ekg.	.....	13,468	13,468
TOTAL	99,140	123,965	24,825
*Maternity Cases (included in above)	9,288	10,131	843

A rate increase was approved effective October 1st, 1955, subject to the following conditions:

(1) 5% of income must be added to Statutory Reserve until it reaches $1,000,000.00.

(2) No additional indemnities shall be made to present schedule without prior consultation with the Insurance Commissioner.

(3) If the total of the Statutory and other Reserves shall at the end of any calendar year exceed five months average incurred benefits, the excess may be returned to subscribers by passing a month's assessment.

PHYSICIANS SERVICE

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Ashworth to fill the vacancy and named Dr. Orland F. Smith as Treasurer and Dr. G. Edward Crane to the Board of Directors.

Highlights of the year included the expansion of the Physicians Service Program to include X-ray and electrocardiograms as part of its coverage; the development of liaison committees in the district medical societies with the Claims Committee; clarification of the position of Physicians Service regarding coverage for mentally ill persons who are subscribers; and the increase in the consultant staff of the Claims Committee.

Physicians Service continued to increase in enrollment during 1955, and it thereby maintains its position as the most successful program of its kind in the nation with the largest percentage of eligible population within its jurisdiction covered.

Appended to this report is a summary comparison of statistics for the years 1955 and 1954.

Respectfully submitted,

ERNEST K. LANDSTEINER, M.D., *Secretary*

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WHY TAKE CHANCES WITH VITAMIN ABSORPTION

when you can prescribe completely aqueous...

VIFORT® Polyvitamin Drops
(A, D, C, and B vitamins)

VIDAC* A-D-C Drops

Clinically tested,[1-3] VIFORT and VIDAC are completely water-soluble and in small particle size for maximum absorption and utilization. The vitamin A in both VIFORT and VIDAC is 3 to 5 times better absorbed than from oily media, with 3 times as much liver storage.[1-4] Ideal for infants and children, good-tasting orange-flavored VIFORT Drops and licorice-flavored VIDAC Drops can be placed directly on the tongue or taken in fruit juices or milk. No fish-oil taste or odor.

Supplied: VIFORT Drops, in 15-, 30-, and 60-cc. dropper bottles. VIDAC Drops, in 15- and 30-cc. dropper bottles. (VIFORT is also available as Capsules.)

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Endo Products Inc., Richmond Hill 18, N.Y.

1. Sobel, A. E., et al.: Am. J. Dis. Child. 80:932, 1950. 2. Davidson, D. M., and Sobel, A. E.: J. Invest. Dermat. 12:221, 1949. 3. Gribetz, D., and Kanof, A.: Pediatrics 7:632, 1951. 4. Sobel, A. E., et al.: J. Nutrition 35:225, 1948.

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Report of Meeting Held on January 25, 1956

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, January 25, 1956.

The following were in attendance when President Frank B. Cutts, M.D., called the meeting to order at 8:15 P.M.:

Kent County: Peter C. Erinakes, M.D.; Edmund C. Hackman, M.D. *Newport County:* Henry W. Brownell, M.D. *Pawtucket District:* Robert C. Hayes, M.D.; Henry E. Turner, M.D.; Hrad H. Zolmian, M.D. *Washington County:* Thomas A. Nestor, M.D.; James A. McGrath, M.D. *Providence Medical Association:* Charles J. Ashworth, M.D.; Robert R. Baldridge, M.D.; Alex M. Burgess, Jr., M.D.; Bertram Buxton, Jr., M.D.; Wilfred I. Carney, M.D.; Francis H. Chafee, M.D.; William B. Cohen, M.D.; Michael DiMaio, M.D.; J. Merrill Gibson, M.D.; Thomas L. Greason, M.D.; Hannibal Hamlin, M.D.; John C. Ham, M.D.; Joseph A. Hindle, M.D.; Albert H. Jackvony, M.D.; Ernest K. Landsteiner, M.D.; William S. Nerone, M.D.; Arnold Porter, M.D.; William A. Reid, M.D.; Louis A. Sage, M.D.; William J. Schwab, M.D.; James J. Sheridan, M.D.; George W. Waterman, M.D. *Officers of the RIMS* (other than Delegates): Frank B. Cutts, M.D.; Charles L. Farrell, M.D.; Thomas Perry, Jr., M.D.

Also in attendance were Arthur E. O'Dea, M.D., Chairman of the Highway Safety Committee; Walter E. Campbell, M.D., Chairman of the Mental Health Committee; Francis B. Sargent, M.D., Chairman of the Medical Defense and Grievance Committee; Richard P. Sexton, M.D., Chairman of the Veterans Affairs Committee; and John E. Farrell, Sc.D., Executive Secretary.

REPORT OF THE PRESIDENT

Dr. Frank B. Cutts reported that he had received a communication from Mayor Walter H. Reynolds of Providence inviting the Rhode Island Medical Society to appoint a committee to make an objective appraisal of the facilities and services at the Chapin Hospital relative to care given to poliomyelitis patients.

He stated that he had invited members of the Society to serve on the committee whom he listed as follows: William P. Buffum, M.D., Chairman; Kenneth G. Burton, M.D.; Marshall N. Fulton, M.D.; Alfred L. Potter, M.D.; Louis A. Sage, M.D.; William P. Shields, M.D.; Raymond E. Stevens, M.D.

Action: The House approved of the action taken by the President in naming the committee and requested that the committee make its report to the Board of Hospital Commissioners of the City of Providence, to the Society and to the public.

Minutes of the Previous Meeting of the House of Delegates

The President noted that the minutes of the previous meeting of the House had been published in the RHODE ISLAND MEDICAL JOURNAL.

Action: It was moved that the report of the September, 1955, meeting of the House of Delegates be approved as published. The motion was seconded and adopted.

REPORT OF THE SECRETARY

The report of the Secretary was presented as follows:

The Council has held two meetings since the last meeting of the House of Delegates. Among actions taken were the following:

1. It authorized the Child Health Relations Committee to issue a special committee release to each member of the Society giving information regarding the Salk-Enders vaccine distribution in Rhode Island.

2. It approved of the appointment by the President of Dr. Richard P. Sexton, Chairman of the Society's Committee on Veterans Affairs, as a member of the General Assembly study committee on hospital-medical benefits for Gold Star Mothers.

3. It authorized the President to appoint a committee from the Council to review the by-laws and to make recommendations regarding amendments to the Council.

4. It went on record as approving the action taken by the Staff Committee of the Roger Williams General Hospital Association regarding industrial physical examinations to be done by the staff on a fee basis at the hospital, and it further prepared and submitted to the Secretary of each district medical society, the Secretary of the Hospital Association of Rhode Island, and the President of each hospital staff association a copy of its opinion on the proposal.

5. It delegated to the Committee on Mental Health the task of determining what should be the best method of supervising the disposition of the medical records of Butler Hospital, after consultation with the Trustees.

6. It authorized Dr. Earl F. Kelly to be the Society's official representative at the Annual Congress on Medical Education and Licensure to be held in Chicago, February 11-14, 1956.

7. It authorized the Executive Secretary to attend the Medical Society Executives Conference Institute in Chicago, Feb. 6, 7 and 8.

8. It voted to support the principles, aims and endeavors of the National Society for Medical Research.

9. It voted that the Society award suitable prizes to the best medical and/or public health exhibit in both the senior and junior high school divisions of the Annual High School Science Fair, and it authorized the President to appoint a committee of three members of the Society to judge these particular exhibits.

10. It approved a report with recommendations for improvements to the Library building as submitted by the Chairman of the Board of Trustees.

11. It authorized the President to appoint a delegate from the Society to attend the national meeting of the American Medical Education Foundation.

12. It voted that a report from the Chairman of the Committee on Medical Defense and Grievance be sent as a direct communication to each member of the Society.

13. It named Dr. Stanley Sprague, Chairman of the Society's Committee on Industrial Health, as the official delegate to the 16th Annual Congress on Industrial Health to be held in Detroit, January 23 and 24, 1956.

14. It approved the annual financial report of the Treasurer for the year 1955.

15. It approved investments of the Suspense Account of the Society held by the Trust Department of the Industrial National Bank, representing interest from investments of the general funds of the Society, and also investments recommended for the Dr. J. E. Mowry Fund.

16. It approved of the actions taken by a special committee named by the Council to consider recommendations from the Library Committee relative to personnel and wages, and it also approved of the establishment of a planned pension program for the employees of the Society, authorizing the President to name a committee to develop such a program.

17. It authorized the Treasurer to pay $311 as the Society's share of the total cost of the entertainment program for the House of Delegates of the American Medical Association in connection with the Clinical Session at Boston in December, 1955, at which the medical societies of New England were hosts.

18. It voted to urge the Board of Trustees of the American Medical Association to recommend to the House of Delegates of that Association Dr. Charles L. Farrell as a nominee for the American Medical Association's Council on Medical Service.

Action: After discussion and inquiry regarding some of the actions taken by the Council it was moved that the Report of the Secretary be received and placed on file. The motion was seconded and adopted.

Recommendations from the Council

The Secretary reported that the Council submitted the following recommendations to the House:

1. That the date of the Interim Meeting of the Society for 1956 be tentatively set as Wednesday, October 24, the place for the meeting to be determined by the Committee on Scientific Work.

2. That the dates for the Annual Meeting of the Society in *1957* be set as April 30, May 1 and 2.

continued on next page

3. That Dr. Charles L. Farrell and Dr. Charles J. Ashworth be nominated as the Society's official representatives on the Board of Directors of the Rhode Island Blue Cross for 1956.

Action: It was moved that these recommendations be adopted. The motion was seconded and adopted.

Nominations for Election to the Board of Directors of Physicians Service

The Secretary noted that the House was required to nominate four physicians to serve for three-year terms, until January, 1959, as members of the Board of Directors of the Rhode Island Medical Society Physicians Service.

Action: It was moved that the physicians whose terms were now expiring be re-elected to the Board of Directors of Physicians Service. These physicians are Charles J. Ashworth, M.D., G. Edward Crane, M.D., Albert H. Jackvony, M.D. and Ernest K. Landsteiner, M.D., all of Providence. The motion was seconded and adopted.

Recess of the House of Delegates

Dr. Cutts announced that the House would recess in order that the Corporation of the Rhode Island Medical Society Physicians Service might conduct its Annual Meeting.

Action: It was moved that the House recess for the meeting of the Physicians Service Corporation. The motion was seconded and adopted, and the House was recessed at 8:40 P.M.

* * *

The House reconvened to continue its meeting at 9:15 P.M.

Resolutions from District Medical Societies

Dr. Cutts called for any resolutions from any of the district medical societies to be presented to the House of Delegates. There were none presented.

Report on the Benevolence Fund

The Executive Secretary reported for the Trustees of the Benevolence Fund noting that one hundred three (103) physicians had contributed a total of $1,731 to date, and that this money had been placed in a savings account at the Industrial National Bank.

Discussion: There was discussion by the members of the House regarding the Benevolence Fund and suggestions were made that an annual request be made of the membership with the Trustees suggesting a nominal sum to be contributed by each member of the Society. Various other suggestions were made and the President requested that Dr. George W. Waterman, a member of the House and a Trustee of the Fund, convey the expressions of the House to the members of the Board of Trustees.

Report of the Delegate to the A.M.A.

Dr. Charles J. Ashworth, Delegate to the American Medical Association, announced that his complete report of the actions taken by the House of Delegates of the American Medical Association at its Clinical Session in Boston would be published in the January issue of the RHODE ISLAND MEDICAL JOURNAL.

He briefly discussed the proposals for amending the Social Security Act and he urged every member of the Society to write to their United States Senators requesting that the Social Security System be carefully studied before further changes are made for additional taxation to increase benefits.

Legislation Relative to Medical Care for Dependents of Military Personnel

The Secretary reviewed communications from the General Manager of the American Medical Association regarding HR 7994, a Congressional act proposing a program for hospital and medical care for the dependents of personnel engaged in the Federal Military Services. He noted that the Council on Medical Service of the American Medical Association had indicated that it would be preferable to have such dependents cared for in civilian hospitals by civilian physicians.

Members of the House discussed various phases of the problem.

Action: It was moved to refer the proposal to the Society's Committee on Federal Medical Services with a request that that Committee prepare and file an opinion with the American Medical Association and the Rhode Island Congressional delegation on this legislation based on the opinions expressed by the House in its discussion. The motion was seconded and adopted.

Report of Cancer Committee

Dr. George W. Waterman presented an information report from his Committee on Cancer relative to the state-wide Conference for Physicians to be held at the Medical Library on Wednesday, March 14, 1956.

Report of the Health Insurance Committee

Dr. Charles L. Farrell read and discussed the report of his Committee, copy of which was submitted to each member of the House and copy of which is also made a part of the official records of this meeting.

Action: It was moved to receive and place the report on file. The motion was seconded and adopted.

* * *

It was moved that the resolution suggested in the Report of the Health Insurance Committee,

continued on next page

RHODE ISLAND HOSPITAL RESEARCH DAY

ALDRICH AUDITORIUM

Wednesday, April 18, 1956 — 10:30 A. M.

EVALUATION OF MAJOR AMPUTATIONS IN PERIPHERAL VASCULAR DISEASE IN RHODE ISLAND HOSPITAL
SEEBERT J. GOLDOWSKY, M.D., AND WILFRED I. CARNEY, M.D.

ANTIHISTAMINICS IN THE PREVENTION OF TRANSFUSION REACTIONS
ENOLD H. DAHLQUIST, JR., M.D., AND HERBERT FANGER, M.D.

GLYCOSURIA IN A GENERAL HOSPITAL POPULATION
ALBERT F. TETREAULT, M.D.

TREATMENT OF THROMBOPHLEBITIS WITH CONSTANT INTRAVENOUS HEPARIN
ERWIN O. HIRSCH, M.D., AND MELVIN HOFFMAN, M.D.

EXPERIENCES WITH A SPECIAL CARE UNIT FOR SURGICAL PATIENTS
J. MURRAY BEARDSLEY, M.D., AND J. ROBERT BOWEN, M.D.

Exhibits

UPPER ARM PROSTHESES
HENRY FLETCHER, M.D.

INTERCOSTAL PULMONARY BIOPSY
DANIEL MOORE, M.D., AND THOMAS PERRY, JR., M.D.

URINARY 17-KETOSTEROIDS IN ACNE VULGARIS IN CHILDREN 11-13 YEARS OF AGE
FRANCESCO RONCHESE, M.D., AND WENDELL T. CARAWAY, M.D.

All Physicians are Invited

that the House of Delegates might adopt a resolution eliminating service benefits in prepaid surgical-medical programs in favor of indemnity benefits, be referred to the Council of the Society for study and report to the House. The motion was seconded and adopted.

Report of the Highway Safety Committee

Dr. Arthur E. O'Dea, Chairman of the Committee on Highway Safety, discussed his report, copy of which was submitted to the members of the House and copy of which is made a part of the official records of this meeting.

Action: It was moved that the Report of the Highway Safety Committee be received, the recommendations contained therein be adopted, and the Committee be requested to continue its work and report further to the House of Delegates on how its recommendations may be implemented. The motion was seconded and adopted.

Washington County Medical Society Resolution on Highway Safety

Dr. Thomas A. Nestor presented the following resolution from the Washington County Medical Society:

WHEREAS it is notable in treating severe injuries resulting from automobile accidents that physicians form the impression that speed is almost invariably a factor in having caused the accident; and

WHEREAS physicians are becoming increasingly distressed by the rising rate of severe injuries and fatalities each year from this cause; and

WHEREAS we can conceive of no reason for driving a vehicle on public highways in excess of forty-five miles per hour which is sufficiently important to out-weigh the possibility of dramatic salvage of lives; and

WHEREAS current commendable efforts to install safety devices and improve road tests will certainly at least leave ill-equipped vehicles in operation for many years and provide a time lag which inexorably takes its toll in death and terrible injury;

BE IT THEREFORE RESOLVED that the Washington County Medical Society voice unanimous desire that legislation on a national level be enacted to direct and enforce the compulsory installation of forty-five miles per hour governors or other mechanical devices on all vehicles operating on public highways, and

BE IT FURTHER RESOLVED that the delegates to the State Medical Society be instructed to introduce this motion for consideration at the state level. If approved by the House of Delegates of the Rhode Island Medical Society, this body shall recommend to the House of Delegates of the American Medical Association that similar action be taken by them.

There was discussion of the resolution by the members of the House.

Action: It was moved that the resolution be referred to the Society's Committee on Highway Safety for consideration in its study of the problem, and that the Committee report on the resolution at the next meeting of the House of Delegates. The motion was seconded and adopted.

Report of the Defense and Grievance Committee

Dr. Francis B. Sargent, Chairman of the Medical Defense and Grievance Committee, announced that a report on the Medico-Legal meeting that he attended in New York would be sent to each member of the Society. He briefly reviewed two grievance cases considered by the Committee in recent months.

Report of the Medical Economics Committee

In the absence of Dr. Eske Windsberg, the Executive Secretary reported for the Committee on Medical Economics as follows:

134 returns were received by the Committee on a card survey relative to the use and possible revision of the Society's Fee Schedule for Governmental Agencies adopted in 1950. The results of

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HOUSE OF DELEGATES

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this survey from one-sixth of the members of the Society was reported as follows: 75 members indicated that the Schedule is used and is of value; 59 indicated that they do not use the Schedule.

On the basis of this survey, the Committee recommends to the House of Delegates that the Fee Schedule for Governmental Agencies be not revised at this time.

Action: It was moved to accept the report of the Committee on Medical Economics. The motion was seconded and adopted.

Report of the Mental Health Committee

Dr. Walter E. Campbell, Chairman of the Committee on Mental Health, read a report from his Committee, copy of which is made a part of the official minutes of this meeting.

Dr. Ashworth questioned the statement of the Committee regarding coverage for mental illness under the Physicians Service Program and after brief discussion this section was amended with the approval of the Chairman of the Committee.

There was general discussion of the report by the members of the House.

Action: It was moved that the report, as amended, be received and placed on file. The motion was seconded and adopted.

* * *

It was moved that the House of Delegates express their concern to the Board of Directors of Physicians Service over the mental health problem, and it encourage the Directors of Physicians Service to continue its study of the problem. The motion was seconded and adopted.

Report of the Public Policy and Relations Committee

Dr. Arnold Porter presented a progress report for the Committee on Public Policy and Relations. He indicated that it was the aim of the Committee at this time to develop methods by which the active work of the Rhode Island Medical Society as an organization may be forcefully brought to the attention of the people of Rhode Island.

Report of the Veterans Affairs Committee

Dr. Richard P. Sexton, Chairman of the Committee on Veterans Affairs, reviewed the proposals that have been presented to the General Assembly during the past two years regarding Hospital-Medical Benefits for Gold Star Mothers. He stated that he is currently chairman of a study committee named by the governor to review the entire matter and he noted the action taken by the Committee on Public Laws of the Society taken in previous years regarding the suggested legislation.

There was discussion of the proposal.

Action: It was moved that the report as given by the Chairman be approved and that the House of Delegates record its disapproval of the proposal for special Hospital-Medical privileges for a Gold Star Mother as has been presented to the General Assembly in recent years.

Adjournment

The business of the House completed the President adjourned the session at 11:30 P.M.

Respectfully submitted,

THOMAS PERRY, JR., M.D., *Secretary*

REPORT OF THE HIGHWAY SAFETY COMMITTEE

The Highway Safety Committee of the Rhode Island Medical Society has discussed the various aspects of safety on the highways related to medicine. The report of these discussions is herewith presented.

Drunken Drivers

The most pressing problem to be considered is that presented by the drunken driver. Prior to a most recent ruling in the Rhode Island Superior Court it was necessary to have medical testimony relating to the unfitness of the driver in question in order to obtain a conviction. There is no doubt that alcohol is a major factor in highway death and morbidity and also in property damage.

The Committee is disturbed when it reads accounts in the daily press of medical testimony in court relative to supposed drunken drivers. It feels that there is definite need for improvement in the testimony offered by physicians who are called upon to examine these drivers.

The law stating that a person arrested and charged with operating a motor vehicle while under the influence of a narcotic or intoxicating liquor has the right to be examined by a physician of his own choice, has been discussed. It is the feeling

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DISTRICT MEDICAL SOCIETY MEETING

PROVIDENCE MEDICAL ASSOCIATION

A meeting of the Providence Medical Association was held at the Medical Library on Monday, February 6, 1956. The meeting was called to order by the President, Dr. Robert R. Baldridge at 8:30 P.M.

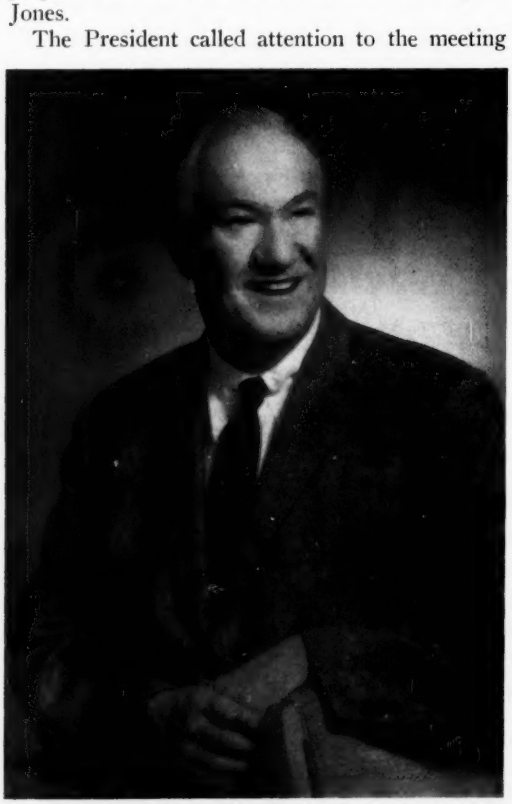
Minutes of the Previous Meeting

The reading of the minutes of the previous meeting of the Association was omitted.

Announcements by the President

The President announced the appointment of Doctors Earl A. Bowen and Charles L. Southey to prepare the Association's tribute to Dr. Henry A. Jones.

The President called attention to the meeting of the Association to be held on March 6 at which Dr. William H. Sweet, Associate Clinical Professor of Surgery at Harvard Medical School is to be the speaker and also to the Cancer Conference to be held on March 14 and the Annual Meeting of the State Medical Society in May.



MARTIN O'BRIEN, M.D.
President, 1956
Washington County Medical Society

Award of Membership Certificates

The President awarded membership certificates to the following: Enold Henry Dahlquist, M.D.; George Andrew Ernst, M.D., and Johannes Virks, M.D., who had been elected at the January meeting of the Association.

Scientific Program

Dr. Arnold Porter, Assistant Surgeon, Rhode Island Hospital presented a paper on *Surgical Emergencies in the Newborn.*

In his interesting paper, Dr. Porter mentioned many of the common emergencies encountered in the new born. Esophageal artresia, he pointed out, in this day and age has 60 to 70% chance of survival as compared with 100% mortality during the early 1930's.

The diagnosis of duodenal artresia is a very simple matter and may be readily made by a flat X-ray film of the abdomen. The treatment of this condition is by surgery and the results are excellent. Jejunal and ileal artresia present the same problem and may be diagnosed in a similar manner depending on the collection of air in the gastro-intestinal tract.

Mal-rotation of the large bowel and imperforate anus are other conditions encountered in new born and which were discussed.

Congenital megacolon, the speaker stated, was caused by pathological innervation of the lower intestinal segment. In other words, this condition is due to improper innervation of the intestine at the abnormal site. He indicated that an easy way to make a diagnosis of megacolon is to take a biopsy of the anal sphincter. The diagnosis of megacolon may be made if the biopsy fails to show ganglion cells which are normally present.

He also discussed meconium ileus which is the name given to a congenital form of pancreatic fibrosis. The treatment of choice of this condition is a double-barreled ileostomy and the use of pancreatic enzymes.

Dr. Vincent Cianci, proctologist, Rhode Island State Hospital for Mental Diseases and Rhode Island State Infirmary, presented a motion picture in sound and color on *Thiersch Operation for Rectal Prolapse.*

The colored movies demonstrating the operation were very well done. The meeting was adjourned at 10:30 P.M.

Attendance was 52.

Collation was served.

HIGHWAY SAFETY COMMITTEE REPORT

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of the Committee that few physicians are willing to do this because of the fear of losing the patient and his family because of hard feelings over the results. If the individual is not a patient the physician probably feels no obligation to respond to the call to examine the driver. The Committee does not feel that the law should be abolished but suggests that the individual be examined first by a competent "police surgeon" and then perhaps the family physician would concur in his opinion.

As a follow up it is suggested that the Society urge all cities and towns in the state to appoint physicians to act as "police surgeons" and that the police departments in the various cities and towns utilize the services of these physicians to examine those accused of drunken driving. In order to obtain the best possible service in this regard, the Committee recommends that the Society urge the physicians acting as "police surgeons" to form an association, preferably within the State Society, for the purpose of exchanging knowledge and to allow all to keep abreast of the latest work related to alcoholism in drivers. This group should consult with experts in the field elsewhere and prepare a booklet on the subject for all members with the assistance of these specialists, the literature and with any others who may aid in its preparation.

It is the feeling of the Committee that the examination throughout the state should be as uniform as possible and that the Society should take it upon itself to arrange a program for these "police surgeons." The trend toward elimination of medical examination of intoxicated drivers should be discouraged because of the chance of missing disease which may masquerade as intoxication.

The Physically Disabled Driver

There was a general discussion of the aged driver, the epileptic driver and drivers with other disabilities. The Committee feels that the examination of the aged driver conducted by the Registry of Motor Vehicles is a worth while project but that the aged driver is not a serious problem at the present time. Periodic eye examinations of all drivers should be conducted, regardless of age.

No conclusions could be reached as to action on cardiac drivers. The general feeling was that it would be almost impossible to find and restrict such drivers. A compulsory registration of all epileptic drivers by the Registry of Motor Vehicles and/or the Health Department would be potentially dangerous since it might discourage epileptics from seeking medical attention. It seems more logical to leave any restriction of these drivers to the private physician on an individual basis. The same might well hold for other conditions such as coronary disease, diabetes, etc.

General Considerations

It is recommended that the Society favor periodic checks of automobile safety devices such as brakes, tail lights, etc. by the Registry of Motor Vehicles and the state and local police departments.

The Committee also favors stricter enforcement and punishment for recklessness, speed and drunken driving.

The Committee urges all physicians to be highway safety conscious and to pass along to all of their patients an awareness of the dangers of unsafe driving.

Respectfully submitted,

HIGHWAY SAFETY COMMITTEE
ARTHUR E. O'DEA, M.D., *Chairman*
CHARLES S. DOTTERER, JR., M.D.
THOMAS H. MURPHY, M.D.
LINUS A. SHEEHAN, M.D.
STANLEY SPRAGUE, M.D.
BENJAMIN F. TEFFT, M.D.
FRANCIS P. VOSE, M.D.

REPORT OF THE HEALTH INSURANCE COMMITTEE

The Health Insurance Committee has approved several policies for two insurance companies during the past few months.

All the insurance companies selling the Rhode Island Plan have been notified of the contract changes and all have acknowledged and agreed to comply with these changes.

In the provision of X-ray benefits Physicians Service is able to change its premium rate at the end of any premium-paying period, which is usually on a short term, such as a three-month basis. In the case of the insurance companies, however, the contract is usually written for the period of one year and the rate is guaranteed. Therefore, any increase in premium rates covering X-ray must meet with the employers' approval. So far, no employers in Rhode Island have agreed to add X-ray coverage, although insurance companies have offered a plan identical with Physicians Service.

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Your Committee considered in great detail all facets of the Voluntary Health Insurance field and noted with interest that employers are offering many and varied plans to cover workers from the hazards of illness and accident, as well as loss of life. One national account has recently offered an all-inclusive plan to its employees in Rhode Island. Your Committee notes with interest the variety and individuality of these several plans and recognizes that a free competitive enterprise system is the best means to develop widespread interest in Voluntary Health Insurance coverage.

Your Committee has cooperated with the insurance companies in the adjudication of claims and is ready at any time to serve any member of the profession that has the slightest difficulty in processing claim forms or in any other area of misunderstanding.

One of the chief causes of irritation in the processing of Voluntary Health Insurance claims is the income limit interpretation.

Instances have been brought to our attention where nurses or employees in the mills have misunderstood the application of the income limit. In Rhode Island where a large percentage of the workers are covered by more than one policy it would seem advisable at this time for the House of Delegates to abolish the income limit and to put the surgical benefits on a straight indemnity basis.

Your Committee notes that Blue Cross is not a Service Plan, but an Indemnity Plan, and the Physicians Service has indemnity schedules for maternity, medical and X-ray coverage, and the only service benefit still in existence is that covering surgery.

Your Committee feels that all services, both medical and surgical, anesthetic and otherwise should be on an indemnity basis and that the payments provided by the insurance Company and by Physicians Service should be a payment toward the cost of the services, and the patient to be charged an additional fee only if circumstances completely warrant it. We are impelled to take this view because there is obviously no abuse of this phase of our plan and we have no complaints on the medical charges, obstetrical, or X-ray charges. There should be none from surgical charges. In some areas, notably in tonsils and circumcisions, additional charges could be made without hardship and could be met easily by a majority of patients, whereas the service benefits in the fee schedule are out of proportion in many instances.

The Committee unanimously recommends, therefore, that the House of Delegates adopt a resolution to the effect that Service Benefits in surgery be eliminated in favor of an indemnity and we are quite confident that the medical profession in

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ON THE MEDICAL LIBRARY BOOKSHELVES

Eight new titles have been added to the Davenport Collection and are available for circulation:

Laurence Farmer, editor — Doctor's Legacy. A Selection of Physicians' Letters, 1721-1954. Harper & Brothers, N. Y., 1955.

John Glaister — The Power of Poison. William Morrow & Co., N. Y.

Richard Gordon—The Captain's Table. Harcourt, Brace & Co., N.Y., 1954.

Michihiko Hachiya—Hiroshima Diary. The Journal of a Japanese Physician August 6-September 30, 1945. Translated and edited by Warner Wells. University of North Carolina Press, Chapel Hill, 1955.

Ernest Jones — The Life and Work of Sigmund Freud. Years of Maturity. 1901-1919. Vol. 2. Basic Books, Inc., N.Y., 1955.

André Migot—Tibetan Marches. Translated from the French and with an Introduction by Peter Fleming. E. P. Dutton & Co., Inc., N.Y., 1955.

Wyman Richardson — The House on Nauset Marsh. W. W. Norton & Co., Inc., N.Y., 1955.

Gordon S. Seagrave — My Hospital in the Hills. W. W. Norton & Co., Inc., N.Y., 1955.

One book was purchased through the Donley Fund:

Donald Hunter — The Diseases of Occupations. Little, Brown & Co., Bost., 1955.

Recent Day Fund purchases were:

Advances in Pediatrics. Vol. VIII. S. Z. Levine, editor. Year Book Publishers, Inc., Chic., 1956.

American Foundation—Medical Research: A Midcentury Survey. 2 vols. Little, Brown & Co., Bost., 1955.

Charles P. Bailey — Surgery of the Heart. Lea & Febiger, Phil., 1955.

Boston Poison Information Center — Procedure Book for the Management of Childhood Poisoning. Bost., 1955.

George E. Burch & Travis Winsor—A Primer of Electrocardiography. 3rd ed. Lea & Febiger, Phil., 1955.

Leo M. Davidoff & Emanuel H. Feiring—Practical Neurology. Handbooks for the General Practitioner. Landsberger Medical Books, Inc. McGraw-Hill Book Co., N.Y., 1955.

Ludwig Edelstein—The Hippocratic Oath. Text, Translation and Interpretation. Johns Hopkins Press., Balt., 1943.

George W. Holmes & Laurence L. Robbins — Roentgen Interpretation. 8th ed. Lea & Febiger, Phil., 1955.

Franc D. Ingraham & Donald D. Matson—Neurosurgery of Infancy and Childhood. Charles C Thomas, Publisher, Springfield, Ill., 1954.

John P. Merrill—The Treatment of Renal Failure. Grune & Stratton, Inc., N.Y., 1955.

The Pharmacopeia of the United States of America. Fifteenth Revision. Easton, Pa., 1955.

Seymour Standish, Jr. & others — Why Patients See Doctors. University of Washington Press, Seattle, 1955.

Mario Stefanini & William Dameshek—The Hemorrhagic Disorders. Grune & Stratton, Inc., N.Y., 1955.

Edward J. Stieglitz, editor—Geriatric Medicine. Medical Care of Later Maturity. 3rd ed. J. B. Lippincott, Phil., 1954.

James C. White & William H. Sweet—Pain. Its Mechanisms and Neurosurgical Control. Charles C Thomas, Publisher, Springfield, Ill., 1955.

Kurt Wiener — Systemic Associations and Treatment of Skin Diseases. The C. V. Mosby Co., St.L., 1955.

Joseph R. Wilder—Atlas of General Surgery. The C. V. Mosby Co., St.L., 1955.

Year Book of General Surgery (1955-1956 series) Edited by Evarts A. Graham. With a Section on Anesthesia edited by Stuart C. Cullen. Year Book Publishers, Inc., Chic., 1955.

Review volumes from the Rhode Island Medical Journal were:

Edgar V. Allen, Nelson W. Barker & Edgar A. Hines, Jr., with Associates in the Mayo Clinic and Mayo Foundation—Peripheral Vascular Diseases. 2nd ed. W. B. Saunders Co., Phil., 1955.

Lawrence R. Boies & others — Fundamentals of Otolaryngology. 2nd ed. W. B. Saunders Co., Phil., 1954.

Russell L. Cecil, Robert F. Loeb & others, editors—A Textbook of Medicine. 9th ed. W. B. Saunders Co., Phil., 1955.

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Council on Pharmacy & Chemistry, A.M.A. — Glandular Physiology and Therapy. 5th ed. J. B. Lippincott Co., Phil., 1954.

J. P. Greenhill—Obstetrics. 11th ed. W. B. Saunders Co., Phil., 1955.

Fontaine S. Hill — Practical Fluid Therapy in Pediatrics. W. B. Saunders Co., Phil., 1954.

Medical Department, United States Army — Surgery in World War II. Hand Surgery. Edited by Sterling Bunnell. Office of the Surgeon General, Wash., 1955.

Robert E. Rothenberg, editor and compiler — Understanding Surgery. Pocket Books, Inc., N.Y., 1955.

Surgical Forum. Proceedings of the Forum Sessions, Fortieth Clinical Congress of the American College of Surgeons, Atlantic City, N. J., November 1954. W. B. Saunders Co., Phil., 1955.

Robert Tauber—Basic Surgical Skills. A Manual with Appropriate Exercises. W. B. Saunders Co., Phil., 1955.

Paul Williamson—Office Procedures. W. B. Saunders Co., Phil., 1955.

Woods Schools — The Exceptional Child Faces Adulthood. Proceedings of the 1955 Spring Conference of the Child Research Clinic. Langhorne, Pa., 1955.

Fellows of the Society have given the following items to the Library:

From *Dr. Peter P. Chase*—Ciba Foundation Colloquia on Ageing. Vol. I. General Aspects. Editors: G. E. W. Wolstenholme & Margaret P. Cameron assisted by Joan Etherington. Little, Brown & Co., Bost., 1955.

Fifty Years of Medicine and Surgery. An autobiographical Sketch by Dr. Franklin H. Martin. Surgical Publishing Co., Chic., 1934.

From *Dr. Joseph Franklin*—243 journals.

From *Dr. Roland Hammond*—medical journals.

From *Dr. Charles Potter*—Directory of Medical Specialists, vol. 5. Marquis, Chic., 1951.

From *Dr. F. Ronchese*—Psoriasi by M. Monacelli & others. Edizioni Minerva Medica, Torino, 1952.

— medical journals and pamphlets.

Other gifts were:

Army Medical Service Graduate School—Notes. Medical Service Company Officer Course. 6 vols. Wash., 1951, 1952. Gift of the Adjutant General of Rhode Island.

Committee on Growth of the National Academy of Sciences & National Research Council—Ninth Annual Report, July 1953-June 1954. Wash., 1955. Gift of the American Cancer Society, Inc.

Fifth Report on Institutional and Special Purpose Research Grants, September 1953-August 1954. N.Y., 1955. Gift of the American Cancer Society, Inc.

American Institute of Management — Manual of Excellent Managements. N.Y., 1955. Gift of the Institute.

Committee on Legislation, A.M.A. — Proceedings of the Regional Legislative Conference, New York, October 29, 1955. Chic., 1955. Gift of the American Medical Association.

Council on National Defense, A.M.A.—Proceedings of Medical Defense Conference, Atlantic City, June 4, 1955. Chic., 1955. Gift of the American Medical Association.

Transactions of the American Proctologic Society, 54th annual session, June 1 to 4, 1955. N.Y., 1955. Gift of the Society.

Ford Foundation—Faculty Salaries, Hospital Support, Medical Education. A statement by the Trustees. N.Y., 1955. Gift of the Foundation.

Butazolidin. 100 Million Patient Days of Therapy. A Review of the Clinical Experience. N.Y., 1955. Gift of Geigy Pharmaceuticals.

Congenital Heart Disease. Report of the Fourteenth M&R Pediatric Research Conference. Columbus, 1955. Gift of the M&R Laboratories.

Annual Report of the John and Mary R. Markle Foundation, 1954-1955. Gift of the Foundation.

Symposium on Sedative and Hypnotic Drugs. Williams & Wilkins Co., Balt., 1954. Gift of the Miles-Ames Research Laboratory & Sumner Research Laboratory.

Diagnostic Standards and Classification of Tuberculosis. N.Y., 1955. Gift of the National Tuberculosis Association.

W. Alan Wright & others — Nutrition in Infections. N.Y., 1955. Gift of the New York Academy of Sciences & Chas. Pfizer & Company, Inc.

Our Smallest Servants. The Story of Fermentation. Brooklyn, 1955. Gift of Chas. Pfizer & Company, Inc.

Administrative Guide to Special Services in the Providence Public Schools, 1952; revised 1955. Gift of the Providence School Department.

American Public Health Association—Control of Communicable Diseases in Man. N.Y., 1955. 8th ed. Gift of the Rhode Island Council of Defense.

Collected Papers of Dr. I. C. Rubin, 1910-1954. N.Y., 1954. Gift of the Author.

Sandoz Scientific Department — The Headache Problem. Gift of Sandoz Pharmaceuticals.

Clifford J. Barborka & E. Clinton Texter, Jr.—Peptic Ulcer. Diagnosis and Treatment. Little, Brown & Co., Bost., 1955. Gift of the G. D. Searle Company.

Chlorpromazine and Mental Health. Proceedings of the Symposium held under the Auspices of Smith, Kline & French Laboratories June 6, 1955. Lea & Febiger, Phil., 1955. Gift of Smith, Kline & French Laboratories.

U. S. Department of Health, Education, and Welfare—Protecting Children in Adoption. Wash., 1955. Gift of the U. S. Government.
Bernard M. Cohen & Maurice Z. Cooper—A Follow-Up Study of World War II Prisoners of War. VA Medical Monograph. Wash., 1955. Gift of the Veterans Administration.
Books in Print, R. R. Bowker Co., N.Y., 1954. Gift of the Veterans Administration Hospital.
7 volumes of the Josiah Macy, Jr. Foundation Conferences. Gift of the Veterans Administration Hospital.
Collected Reprints from the Wilmer Ophthalmological Institute, vol. XII, 1954-1955. Gift of the Institute.

RHODE ISLAND MEDICINE. The Washington County Medical Society has deposited the following volume at the Library: RECORDS OF THE WASHINGTON COUNTY MEDICAL SOCIETY January 31, 1884-October 8, 1947. We are happy to add these Records to our collection of material pertaining to the history of medicine in Rhode Island.

HEALTH INSURANCE COMMITTEE REPORT

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Rhode Island will do its share toward proper adjudication of fees in the surgical field as it has done in the medical field.

Respectfully submitted,
HEALTH INSURANCE COMMITTEE
CHARLES L. FARRELL, M.D., *Chairman*

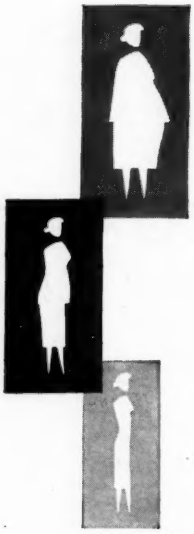
Monday, April 2
REGULAR MEETING
of the
PROVIDENCE
MEDICAL
ASSOCIATION
at the Medical Library,
8:30 P.M.
Panel on:
"Complications of Some Widely-used Drugs"

In all your pregnant patients

1. Diet is important

2. . . . *and so is adequate supplementation*

for prenatal vitamin-mineral protection, choose between



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